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What Works in Psychotherapy?

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E-mail: eap.admin@europsyche.org
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The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and also internationally. It is properly (double-blind) peer-reviewed.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students. The Journal is published by the European Association for Psychotherapy (EAP), three times per annum. It has been published for 24 years. It is currently working towards obtaining a listing on several different Citation Indices and thus gaining an Impact Factor from each of these.

The focus of the Journal includes:

- Contributions from, and debates between, the different European methods and modalities in psychotherapy, and their respective traditions of theory, practice and research;
- Contemporary issues and new developments for individual, group and psychotherapy in specialist fields and settings;
- Matters related to the work of European professional psychotherapists in public, private and voluntary settings;
- Broad-ranging theoretical perspectives providing informed discussion and debate on a wide range of subjects in this fast expanding field;
- Professional, administrative, training and educational issues that arise from developments in the provision of psychotherapy and related services in European health care settings;
- Contributing to the wider debate about the future of psychotherapy and reflecting the internal dialogue within European psychotherapy and its wider relations with the rest of the world;
- Current research and practice developments – ensuring that new information is brought to the attention of professionals in an informed and clear way;
- Interactions between the psychological and the physical, the philosophical and the political, the theoretical and the practical, the traditional and the developing status of the profession;
- Connections, communications, relationships and association between the related professions of psychotherapy, psychology, psychiatry, counselling and health care;
- Exploration and affirmation of the similarities, uniqueness and differences of psychotherapy in the different European regions and in different areas of the profession;
- Reviews of new publications: highlighting and reviewing books & films of particular importance in this field;
- Comment and discussion on all aspects and important issues related to the clinical practice and provision of services in this profession;
- A dedication to publishing in European 'mother-tongue' languages, as well as in English.

This journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe and world-wide. We have recently developed several new 'Editorial Policies' that are available on the IJP website, via the 'Ethos' page: **www.ijp.org.uk**

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The IJP Website: www.ijp.org.uk

The IJP website is very comprehensive, with many different pages. It is fairly easy to negotiate using the tabs across the top of the website pages.

You are also able to subscribe to the Journal through the website – and we have several different 'categories' of subscriptions. However, the Journal is now more of an "open-access" journal, so subscriptions are less relevant.

You can also purchase single articles and whole issues as directly downloaded PDF files by using the Catalogue on the IJP website. Payment is by PayPal. We still have some printed copies of most of the Back Issues available for sale.

Furthermore, we believe that **'Book Reviews'** form an essential component to the 'web of science'. We currently have about 60 books available to be reviewed: please consult the relevant pages of the IJP website and ask for the books that you would enjoy reviewing: and – as a reviewer – you would get to keep the book. All previously published Book Reviews are available as free PDF files.

There is also a whole cornucopia of material that is currently freely available on-line (see the top left-hand corner of the website). **Firstly**: there are several "Open Access" books on Psychotherapy available, free-of-charge; **next** there are an increasing number of free "Open Access" articles; **then** there are often a couple of articles available from the forthcoming issue, in advance of publication.

There is also an on-going, online 'Special Issue' on **"Psychotherapy vs. Spirituality"**. This 'Special Issue' is being built up from a number of already published articles and these are available freely on-line, soon after publication.

Finally, there are a number of previously published **Briefing Papers**. There is one on: *"What can Psychotherapy do for Refugees and Migrants in Europe?"*; and one on an important new direction: *"Mapping the ECP into ECTS to gain EQF-7: A Briefing Paper for a new 'forward strategy for the EAP."* Because of a particular interest that we have in what is called by "Intellectual Property", we have included a recent briefing paper: *"Can Psychotherapeutic Methods, Procedures and Techniques" be patented, and/or copyrighted, and/or trademarked? – A Position Paper."* Lastly, as part of the initiative to promote psychotherapy as an independent profession in Europe, we have: *"EAP Statement on the Legal Position of Psychotherapy in Europe"*, which we published in a recent issue.

International Journal of Psychotherapy

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear Readers and Fellow Psychotherapists

This first section of the Editorial is something of a personal statement. I am approaching the end of my professional life, because – currently – I am about 75 years and 6 months of age, and in indifferent health, and I have been working in this profession in a variety of ways for the last 45+ years or so. I am also currently trying to 'hand over' some of the editorial work and responsibilities. That gives me, I believe, a little bit of "street cred".

So – this is my (sort of) "swan song". I have no other agenda. I am not dying dramatically on stage; I am not trying to create something like a legacy – although I hope that some (a few) of my ideas might survive for a while and influence others a bit; I have no financial aspirations or dreams of grandeur; I am (definitely) not setting myself up as a guru, or a 'teacher', or a Leader; etc. I am currently just trying to step down (and/or stepping back) from this particular position (as Editor of the ***International Journal of Psychotherapy***) that fate has led me (gifted me) to hold for the last 15 years or so; and that has been such a privilege and a blessing, which I have tried to respect and hold in a somewhat sacred trust.

However, at this crucial point in time (and given this privilege), I – inevitably – also risk abusing this position and this trust. So, I am not totally sure about what I am about to do: I am taking a considerable risk. I hope it pays off and that you (our readers) get some value from it.

For several years (about 20-30) in my professional practice as a psychotherapist and counsellor, in the NHS in Scotland, in private practice, and nationally

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(in the UK and Europe), and also in the "politics" of psychotherapy (in the UK and Europe) – where we have been trying to establish an independent profession of Psychotherapy – and where we have been trying to 'legitimise' all the different branches / modalities / methods / techniques and practices of this diverse profession of Psychotherapy – and where we have been 'blighted' (and enriched) with the diversity of branches / modalities / methods / techniques and practices – in a similar way (perhaps) as the Christian church has been blighted (or enriched) by all the different methods of worship ... I have just struggled just to do my best for my clients.

Perhaps, I have been privileged – living in a 'rich', Westernised society, coming from a privileged, 'white', 'male', 'straight', background, etc. – but I have genuinely tried to help 'others' – those people sitting in front of me – who are struggling, in pain or distress, confused and hurt by what has happened to them: otherwise, they would not be there.

I have also had a couple of 'complaints' lodged against me over the course of the last 40 years: ultimately, there has always been "no case to answer" and my work (and my rationales for what I have done) has been accepted. Obviously, what I have done with those particular clients (or their close associates) who lodged the complaints, didn't work for them. This is – of course – distressing (to me as well as to them), but it is also somewhat inevitable: an occupational hazard.

As a '*contra-point*', I have often heard from clients their dissatisfaction with their former counsellors or therapists: not just dissatisfaction with the 'method' (usually CBT), but also with the attitude of the (often 'Humanistic' or 'Analytic') counsellor, who just seemed to be 'stuck' in their method and thus to be unresponsive to the person, the client in front of them.

Usually, I just let whatever is in me come out (mildly censored). I am not concerned – particularly – with political correctness, or professional 'ethical' speech. I try to be real; I try to be open empathically; and I say what I feel as a genuine response. Mostly, this sort of relational approach seems to work.

At several times, I also have 'recorded' the clients' progress in 'scores' (using HADS or CORE [1]) and have had pretty good results. But this has been mainly because I have people 'over me', who want to see 'results': and my results have reasonably satisfactory, as most of my patients / clients have got significantly better (according to these measurements) within a reasonable time-frame. [2]

1. HADS: Hospital Anxiety & Depression Scale. CORE-IMS: Clinical Outcomes in Routine Evaluation - Information Management System.
2. In another article (and other articles), I describe – in much more detail – my professional practice of counselling and psychotherapy: see my website: www.courtenay-young.com

Now, I am not 'elevating' psychotherapy to the status of a religion or a religious practice (or maybe I am) because I think that psychotherapy does as much, or more, to soothe the psyche (soul) as any religion, sect, practice or creed.

Most of the time, I am simply stating – sincerely – that 'IT' (psychotherapy) – this interaction between I and Thou, works! And I am trying (hard) to get this 'belief system' across to the person in front of me so that they go out of the room with a modicum of hope.

So, that is the basic theme of this "Special Issue" (or this 'swan song') – what actually works! This Special Issue of the IJP on 'What Works in Psychotherapy (and Counselling)' – is not just from my perspective; nor just from any personal belief or predilection; nor just from my particular training and experience; nor just from randomised controlled trials (RCTs) – the so-called "gold standardised" of political (scientific) correctness in psychology; but mainly from the perspective of the patient or client – the people that we serve: those in need – sometimes in desperate need.

These people are our "raison d'être": these people are why we are here in this profession; these people are those we "serve" – or are supposed to serve (irrespective of who pays). Despite our predilections, or our professional training, or our lack of perspicaciousness, we owe something to these people, these are the people who pay us to get it RIGHT – for Them!

So – the theme of this 'Special Issue' is **"What Actually Works in Psychotherapy (and Counselling)?"** And I don't have any particular answer to this question, but I will try to give a selection of answers and therefore, you can start to chouse 'what works for you': this is the essence of what I call – with tongue in cheek – ***Functional Psychotherapy***.

I believe that we (the professionals) have to – are required to – find the "right" answer for the person in front of us: the client.[3] Given this way of thinking, we are somewhat like an architect who has a client who want them to build them a house. Irrespective of the house that I grew up in, or presently live in, I would need to discover what sort of house would work for (satisfy) the client in front of me. Do they have a particular profession, or lifestyle, or hobby, or location? Do they have children? What sort of environment would they like to live in, or what would their husband or wife like?

At the start of the interview (session), I have absolutely no idea: I am like a doctor who sees a patient for the first time. Yet, I am a different professional: this is not a 'medical' problem. It is my job to find out what is causing distress and

3. Let me state here – emphatically – that I do not subscribe to the "medical model" whereby a psychotherapy client is a "patient". Most of our 'clients' are not ill, sick, or disabled: of course, some are, but let us not de-humanise them or diminish them in any way. As a psychotherapist, our clients just want some help: they are in distress, hence the appointment.

to help the 'client' to alleviate or fulfil their need. Actually, I would go one step further and say that it is my job to find out how to help the client discover how they can fulfil their need, or how they can lessen their distress.

This interaction could also be somewhat similar to a solicitor, with a client who wants to make a will: Initially, I have absolutely no idea what they want; what would work for them; how they want to leave their assets? But, it is my job to help them to facilitate their concepts.

One of my early 'teachers' said that – once one had learnt their (Biodynamic) 'method' of psychotherapy – one could be a Biodynamic plumber, or psychotherapist, or whatever: they were teaching an "approach", not a method. So, maybe, I am promoting an "approach".

If I was 20 or 30 years younger, I might possibly call this approach (something like) "Functional Psychotherapy" (albeit there is already a 'method' called "Functional Analytic Psychotherapy"[4]), however, there are between 400-600 different 'types' of psychotherapy, so labels don't really matter much. I am not interested in the particular method; I am just interested in "what works". So, here goes!

In the second section of this Editorial, I introduce this concept or topic – more experientially and theoretically. Several years ago, I presented a PowerPoint seminar at a university counselling course, which I feel now was the first stirrings of this theme. It was reasonably well received (though one person seemed to react negatively) and occasionally I developed it a bit further. More recently, I decided to revise this PowerPoint into a plenary presentation at an Integrative Psychotherapy conference in Tbilisi, Georgia.[5] Subsequently, I wrote up this presentation into an article: but it ran into about 35,000 words: much too long for a 'normal' journal article and too short for any other type of publication: I was therefore unsure what to do with it. A colleague said they would try to edit it, but I haven't yet anything heard back.

More recently, as the Editor of this Journal, we found that we were stuck for a scheduled issue – as our plans for a Special Issue on Integrative Psychotherapy (based on this conference) became delayed.

At about this time, I had received an 'inspection copy' of a book entitled, **(a)** "*Psychotherapy Skills and Methods That Work*", edited by Clara E. Hill & John C. Norcross (Oxford University Press, 2023). This volume was much more interesting and informative – "a massive collaboration" – than a previous vol-

4. www.societyforpsychotherapy.org/functional-analytic-psychotherapy-fap-using-awareness-courage-love-treatment
5. 11th Integrative Psychotherapy conference, Tbilisi, Georgia, 2023: www.euroaip.eu/the-11th-european-conference-of-integrative-psychotherapy

ume that had also been sent for inspection: **(b)** *"A Guide to Treatments that Work (4th Ed.)"*, edited by Peter E. Nathan & Jack M. Gorman, (Oxford University Press, 2015). This latter volume was much more 'scientific', dealing mainly with randomised controlled trial (RCT) results. But both volumes are fairly massive (and expensive) and therefore fairly unlikely to come into the hands of our readers. Incidentally, the Hill & Norcross volume has about 65 authors, 23 chapters, and about 720 pages; the Nathan & Gorman volume has about 73 authors, 28 chapters and about 960 pages. So, there are now three 'streams' that feed this particular issue of the IJP.

It is therefore my intention to try to disseminate some of this 'information' and 'wisdom' and 'knowledge' in this Special Issue to you, our IJP readers.

Let me now quote some words from the 22-page "Introduction to Psychotherapy Skills and Methods That Work".

> *Imagine yourself sitting [as a client] in a session with a psychotherapist. Of course, you want to feel safe in that setting, respect the therapist, enjoy a strong relationship, agree on treatment goals, and feel motivated to do the work. All well and good, and all predictive of and contributing to your eventual treatment success. But you also want the psychotherapist to do something to help you. It would rarely suffice for them to be only a nice, warm, real person …*
>
> *The main thesis of this book is that skills and methods contribute substantially to the outcome of psychotherapy* ***in addition to*** *many other elements, such as the client, the therapist, their relationship, and external pressures. What therapists* ***do*** *makes a meaningful difference, although there are often a number of skills and methods that might prove helpful or hindering in any one situation … [and] …there is, surprisingly, less empirical support for the effectiveness of specific therapist skills and methods. It is our hope that this book helps therapists implement skills and methods in a way that optimizes psychotherapy outcomes.*

And so, this is the 'nub'! What lies in between the "nice, warm, real person", and the needs of the person (client) who has come for help, and a reasonably optimal outcome? There is a 'something' that relates to what the therapist actually does: their choice of techniques, their skill-set, their empathy, their compassion (and how they demonstrate that), their intuitive sense of what that person needs, their suggestions and what the client takes away with them and then implements. This is a very complex mix.

One of the labels that Functional Analytic Psychotherapy (FAP) uses is "contingent responding": a dialogue (back-and-forth conversation) in which the therapist follows the client's lead by responding to their comments or questions in a way that keeps the conversation going; or that 'reinforcement theory' suggests that behaviours, when given the right type of reinforcement, can be changes for the better or negative behaviour can be discouraged. This latter description is slightly too 'clinical' – almost being benignly manipulative. It is

fairly self-evident that – given a commitment to the therapy and a reasonably positive relationship – any suggestions from the therapist might well be followed up and the result might be even be positive.

One of my 'teachers' said that they supported a "midwife approach" in that the therapist was just present and supportive for the client's process, but they didn't do much unless it became necessary: so, they "guided from behind". This has stuck with me. Another maxim is that I often use is to say that I am working quite hard to make myself 'redundant' with a client – so that they don't need any more sessions. Then I can see someone else, or I can go sailing. It can also be worth keeping a tally of 'drop-outs'.

In one clinic, about 12% of the doctors' referrals never took up the invitation – i.e. were never seen; and about 12% 'dropped out' after 1 or 2 sessions – i.e. it didn't 'work' for them. The rest got about 6-8 sessions (av. 7 +/-) and we managed to get about 95% of their CORE scores down to a non-clinical level. My employers seemed to be very happy with that and so I worked there giving about 8-10 sessions p.w. for 19 years. There is less of an incentive to keep such statistics in private practice, but it is very worthwhile.

You will also find two books reviews on this topic. The first is *"Psychotherapy Skills and Methods that Work"*, edited by Clara E. Hill & John C. Norcross. This book came out very recently and I sent away for an inspection copy. It should probably be compulsory readiung and a textbook for all psychotherapy training institutes of whatever modality.

The second book review is *"A Guide to Treatments that Work (4th edition)"*, edited by Peter E. Nathan & Jack M. Gorman. This is a much more 'heavier' tome (both literally & figuratively), intended more for specialist and scientific study. It is quite medically and pharmacologically oriented: a sort of psychological 'companion' to DSM-5, though not very helpful for psychotherapists.

We hope you enjoy all these contributions.

What Works in Psychotherapy (& Counselling)?

Courtenay Young

Abstract: This extended article was developed from an original PowerPoint presentation first given at the Strathclyde University to a group of counsellors in Sept. 2015 and given again (most recently) at the 11th Conference of the European Association of Integrative Psychotherapy, in October 2023 in Tbilisi, Georgia. It focuses on What (we actually know) Works in Psychotherapy and Counselling – and therefore also, by default, what doesn't seem to work, all based on considerable research findings. This is therefore a pragmatic collection of 'proven' approaches, techniques and methodologies that can be (mostly) applied in any modality of psychotherapy.

Key Words: psychotherapy, counselling, efficacy, research, contra-indications

Introduction

This article isn't about any particular method or modality of psychotherapy being better than any other: as the "Dodo Bird" verdict implies, as basically all therapies are equally effective in that they all seem to produce equally effective outcomes.[1] And it isn't about developing a good therapeutic relationship – as that is a necessary and essential part of one's basic psychotherapy training. And it isn't about 'artificial' distinctions between … psychotherapy, counselling, psychological therapy (IAPT), guided self-help, coaching, etc.; and it isn't about randomized controlled trials, empirically supported therapies, evidence-based practice, effect-sizes, risk-factors, etc.[2]

It also isn't about professional competencies or national occupational standards – which

1. See **Barlow, 2010**; **Benthall, 2009**; **Luborsky, 1999**; **Luborsky *et al.*, 1975**; **Luborsky *et al.*, 2002**; **Luborsky *et al.*, 2006**; **Rosenzweig, 1936**; **Wampold, 2001**.
2. Many of these 'controls' are 'supposed' to ensure that we "do no harm"! - i.e., If psychotherapy is powerful enough to do good, it may be powerful enough to do harm: See: **Castonguay *et al.*, 2010**; **Dimidjian & Hollon, 2010**; **Young, 2014**.

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is what everyone is supposed to be able to do (Young: EAP Competences, 2013; Atherne *et al.*, 2018; Mind, 2009).[3] And it isn't about anyone's particular views about 'mental health' or 'mental illness': i.e. the 'medical model', etc. versus the more humanistic view, client-centred, or context-based, practice; and it has nothing at all to do with ethics and professional behaviour – which is about how one **ought** to be working – or how one ought **not** to be working. And it has also nothing to do with any psychotherapy or counselling associations like UKCP, or BACP, or COSCA, or APA, or EAP, or EAIP, … and all their different Ethical Principles and Codes of Practice, etc. And, finally, it is only very partially about what I myself do – because what works for **me** with **this** person, probably won't work for **you** with **that** person (and vise versa).

So therefore, what this article is about is a sort-of pragmatic 'hotch-potch', backed up by considerable research the various ingredients of which include: "The Common Factors Theory"; "Some 'Therapists' Are Better than others and Some 'Treatments' Are Better (for some things) – STAB"; "The Four Magic Words"; "WOOPS"; "The Great Divide ⇒ CPRN"; "Critical Psychotherapy & Counselling"; "Real Therapy & 'The Big Issues'"; "Mindfulness"; "Myths about Counselling & Psychotherapy"; "What Doesn't Work", etc.; and … (hopefully) also some good ideas – in due course – that come from other people, like yourselves!

The Common Factors Theory vs. The Recovery Model

The 'Common Factors Theory' has – as its basis – an article by Saul Rosenzweig (1936) and it was then developed further by Goldfried (1982) and Oettingen *et al.* (2015). The theory proposes that different approaches and evidence-based practices in psychotherapy and counseling share a number of common factors that account for much of the effectiveness of a psychological treatment. This theory has since been advanced by various meta-analyses, but this (in itself) has significant advantages and disadvantages[4]

Realistically, there are certain advantages and disadvantages to this theory – and there have also been some significant developments since its origin.[5] Most "common factor" theories reduce the 'common factors' down to about five: **(i)** client characteristics and expectations; **(ii)** therapist qualities, like empathy; **(iii)** change processes, including cultural adaptation; **(iv)** the treatment structure and differences; and **(v)** the therapeutic relationship or 'alliance'.[6]

Lambert (1992) also identified four common factors: **(a)** extra-therapeutic change factors – qualities in the client or their environment; **(b)** common factors, such as empathy and the therapeutic relationship; **(c)** expectancies – from the client's belief in the rationale or effectiveness of the therapy; and **(d)** special techniques – unique to the therapy or tailored to the problem.

3. See **Young, 2013**; **Atherne *et al.*, 2018**; **Mind, 2009**.
4. **Meta-Analysis**: See Hilda Bastian (2014): PLOS Blogs: 5 Key Things to Know about Meta-analysis: http://blogs.plos.org/absolutely-maybe/2014/01/20/5-key-things-to-know-about-meta-analysis. And also: Hilda Bastian (2015) Another 5 things to Know about Meta-analysis: http://blogs.plos.org/absolutely-maybe/2015/06/30/another-5-things-to-know-about-meta-analysis
5. See **Martin *et al.*, 2000**; **Wampold, 2001, 2015**; **Horvath & Bedi, 2002**.
6. See **Grencavage & Norcross, 1990**.

Table 1. *Summary of Early Treatment Stage Principles and Techniques Contributing to Positive Therapeutic Outcome*

Fostering positive expectancies

Develop a plausible rationale or conceptual scheme for symptoms
Utilize qualities and techniques designed to enhance the therapeutic relationship (e.g., flexibility, alertness, honesty, accurate interpretation, and fostering affective expression)
Identify an explicit treatment course geared at alleviation of problems
Engender confidence in the treatment process (e.g., invoke evidence and experience for treating patient concerns)
Identify commitment to the therapeutic relationship and process Normalize patient concerns

Role preparation

What is the treatment frame? (e.g., length, duration, frequency, fee)
What is the patient's role in treatment?
What activities are they suggested completing?
What types of content should they expect to focus on?
What will the therapist contribute to the process? (e.g., What is the treatment rationale for how techniques will contribute to treatment change?)

Collaborative goal formation

Clarify concerns leading patients to seek treatment
Identify short-term and long-term goals
Identify goals across a range of functioning
Develop a method for assessing treatment changes over time
Regularly review progress towards treatment goals
- Highlight adaptive changes
- Identify areas for continued growth
- Compare and contrast current and past functioning

Defife & Hilsenroth (2011)

All these different (common) concepts were subsequently developed into the fairly definitive APA book by Duncan, Miller & Wampold (2nd Ed., 2009), *The Heart and Soul of Change*.

Common factors among psychotherapy approaches that have been associated with positive outcomes and therapeutic changes also include: the ability of the therapist to inspire hope and to provide an alternative and more plausible view of the self and the world; the ability to give patients a corrective emotional experience that helps them to remedy the traumatic influence of his previous life experiences; the therapeutic alliance; positive change expectations; and beneficial therapist qualities, such as attention, empathy and positive regard.[7]

7. See **Stricker & Gold, 2001**; **Feixas & Botella, 2004**; **Norcross & Goldfried, 2005**; **Constantino *et al.*, 2011**; **Horvath *et al.*, 2011**.

DeFife & Hilsenroth (2011) identified three 'common factor' core psychotherapeutic principles: **(A)** fostering positive expectancies (first by identifying symptoms, then developing an understanding or rationale for these, and then using the therapeutic relationship to normalize concerns and communicate realistic confidence in the treatment process); **(B)** role preparation involves 'educating the patient/client' in the therapeutic process (by using videos, socialization interviews, key questions and answers, the use of various strategies, and information about the therapist's role); and **(C)** collaborative goal formation (again using the therapeutic relationship to agree on goals, assign tasks, and develop the therapist-client bond). Although the 'common factors' differ, depending on the orientation and the choice of studies, they also indicate concepts and processes that seem to work, despite the various types of psychotherapy or counselling involved. You should have encountered these, or some of these, or they should have been emphasised, in your basic psychotherapy training.

Unfortunately, in the 1990s, the whole debate became overtaken by the increased emphasis – mainly from US insurance companies and the 'Big Pharma' drug companies – on empirically supported treatments (EST) for various particular problems, emphasizing randomized controlled trials (RCT) as the 'gold standard', and the American Psychological Association (Div. 12: Clinical Psychology) even developed 'lists' of ESTs – and also (black) lists of what techniques were not 'supported'; however this approach was criticized by Wampold (2001) as an over-emphasis on EST, and the debate reverted back a little towards the significance of the Common Factors.

This culminated in a 'special edition' of the APA's journal: *Psychotherapy*, which attempted to: *"provide [not only] a perspective as an additional evidence-based approach for understanding how therapy works, but also as a basis for improving the quality of mental health services."* It listed "ten things to remember" (Laska & Wampold, 2014) that: **(1)** Common Factors *are* imbedded in a scientific theory; **(2)** The 'mechanisms of change' in ESTs are ill-specified; **(3)** Common Factors models are not a closed system; **(4)** There is no such thing as a "Common Factor" treatment – and the issue of structure; **(5)** Anomalies: Deal with them; **(6)** What are the conjectures underlying EST theory?; **(7)** Common Factors does not imply 'one size fits all'; **(8)** What is omitted is important; **(9)** RCTs are not the only path to knowledge; and **(10)** "Different Thinks for Different Shrinks". This is thus both a refutation of the EST-model and a defence of the CFT-model.

So, the whole point of the "common factor theory" (CFT) is that there are some distinct 'common factors' within empirically demonstrated and/or 'successful' therapies and that examination of these can improve the quality of a practitioner's (your) therapeutic services. A sub-section of the Common Factors model includes the Recovery Model (RM) of therapeutic change (Reisner, 2005), which tries to differentiate slightly between the CFT, the ESTs and the RMs and yet find a balance between these. Its conclusion is worth reading, but – for more detail – you will have to do your own reading and research.

The Recovery Model

This is more theoretical, philosophical, and more systemic: a 'stage' model of change, which also reflects the client/patient's choice: it is their recovery, after all. This model emphasizes self-determination, responsibility and dignity: above all, it gives hope that recovery from mental illness or from mental health difficulties, is possible and the goal of the therapy is to help people achieve their fullest potential. In practical terms therefore,

the psychotherapist is working to make themselves redundant. This is perhaps easier to do given a 'medical model': the patient leaves the hospital or clinic. Given the intense psychotherapeutic relationship and the (often high) level of attachment, the process of separation can be difficult for both. But this is the measurement of success. It is somewhat easier to do in a clinic with guidelines as to the number of sessions, but – even in private therapy – the therapist should be monitoring the number of sessions, using supervision effectively and using regular outcome measures to assess the client's progress. The psychotherapist should also be considering what else – other resources, people, social and environmental conditions – would support the client and that this should be a frequently discussed topic: i.e., looking forward as well as trying to identify what went 'wrong' in the past and that brought the client to therapy. It is a constant interweaving of these past and future dynamics, with a equally constant focus on what is happening in the moment, in the client, in the therapist, and in the relationship. It is not quite so crude as 'goal-setting', but it does support the view that: (a) that and that and this happened; (b) we are here now – and this present moment is very important – and (c) that the client will be moving on, doing things differently, and developing new (possibly healthier) relationships, that all go towards giving their life greater meaning and themselves better well-being. This process should also build resilience, so that there is less chance of a relapse. The importance of the client's individual support systems – including family, friends, other groups, other professionals, social support and activities (including religion, if appropriate), etc. (Young, 2010; Slade, 2017)

Solution Focused Therapy

Scott Miller, a pupil of Mike Lambert, and author of (2013), *'Why Most Therapists are Average (And How We Can Improve)'*, developed what he calls 'Solution Focused Therapy" out of the Common Factors Theory, in which he emphasizes that we, as therapists, need to learn, grow and be more effective with clients by systematically monitoring therapy outcomes, inviting negative feedback, and asking the simple question that seems often too difficult for therapists to ask: "How is this working for you?" This involves taking systematic measurements and using some deep contextual knowledge to develop one's practice. This is not just a development from studying the common factors effects of psychotherapy but is actually implementing the findings: *"The difference between the best and the rest is what they do before they meet a client and after they've met them, not what they're doing when they're with them."*

Daryl Chow is another member of the International Center for Clinical Excellence, author of (2014), *The Study of Supershrinks: Development and Deliberate Practices of Highly Effective Psychotherapists*, whose research indicates that, within their first eight years of practice, therapists with the best outcomes spend approximately (please note) more than seven times the number of hours on study and contemplation than the bottom two-thirds of clinicians engaged in these kinds of activities.

As an aside, it is perhaps worth mentioning that some of the most brilliant psychotherapists work quite uniquely – often idiosyncratically, even bizarrely – and yet they seem to do good therapy and get good results, so this is not just about techniques or methods, it is as much or more about the type of contact and the attitudes of both therapist and client. It is perhaps worth repeating that the initial contacts, especially the first few minutes of the first session, are thus very important.

Some Therapists Are Better (than others) and Some Therapies Are Better (for some things)

> Therapeutic effectiveness is even a term whose definition is debatable. A patient can achieve simple symptom relief without addressing any of their underlying issues. Sometimes addressing those underlying issues is a longer, more painful, and challenging course, but ultimately results in a more meaningful conclusion. By whose definition would either of those outcomes be considered 'effective'?

The concept of therapeutic effectiveness (which uses the acronym 'STAB') is contentious and yet research also indicates that there is something 'there', as well. Published by the APA Education Directorate, Bruce Wampold's short paper (2011), *The Qualities and Actions of An Effective Therapist*, was supposed to give the definitive answer, unfortunately it provoked some controversy, as well.

However, according to Wampold, there are 14 characteristics of qualities and actions that identify 'effective' therapists: **(1)** Effective therapists have a sophisticated set of interpersonal skills including: verbal fluency; interpersonal perception; affective modulation and expressiveness; warmth and acceptance; empathy; and a focus on the other person; **(2)** Clients of effective therapists feel understood, trust the therapist, and believe the therapist can help him or her; **(3)** Effective therapists are able to form a working alliance with a broad range of clients; **(4)** Effective therapists are able to provide an acceptable and adaptive explanation for the client's distress; **(5)** The effective therapist provides a treatment plan that is consistent (relevant) with the explanation provided to the client for the source of their distress; **(6)** The effective therapist is influential, persuasive, and convincing; **(7)** The effective therapist continually monitors their client's progress in an authentic way; **(8)** The effective therapist is flexible and will adjust the therapy if the client is not responding positively, if any resistance to the treatment is apparent, or if the client is not making adequate progress; **(9)** The effective therapist does not avoid difficult material in therapy and uses such difficulties therapeutically; **(10)** The effective therapist communicates hope and optimism; **(11)** Effective therapists are aware of their client's characteristics and context; **(12)** The effective therapist is aware of his or her own psychological process and does not inject his or her own material into the therapy process, unless such actions are deliberate and [likely to be] therapeutic; **(13)** The effective therapist is aware of the best research evidence related to the particular client, in terms of treatment, problems, social context, and so forth; **(14)** The effective therapist continually seeks to improve. So, there you have it!

Except that Whitbourne (2011) 'dumbed down' these (somewhat plagiaristically) to 13 characteristics, and Gladding (2015), in a presentation at a conference in Singapore, identified only 8 'H' characteristics needed for effective counsellors: Heart (feelings, affect); Head (quick thinking, observing, listening); Hurt (that has been healed or resolved); Holistic (seeing another person in their entirety); Hope (optimism, life can be better); Hold (insight, tongue, advice: be patient); Humanity (a genuine love for people; altruism, selfishness); and Humor (an ability to see the absurd, the lighter side of life).

I am sure there are many such other presentations (with or without the alliteration) – also based on research findings – so, maybe you need to find what it is that you are looking for and especially what works for you: more on that later!

When we consider the other aspect of 'STAB' – that some treatments (or therapies) are better for some things than others, we find an even greater controversy and differences of opinion. Quite clearly, there is absolutely no "Magic Bullet", no "One Size Fits All", especially if you take the most common reason for going into therapy, which is mild to moderate anxiety and/or depression. For some people, anti-depressants are a lifesaver; for others, an anathema; and for others (about 60%), a combination of SSRIs and counselling actually works best. [8] There is even hope for people with recurrent episodes of depression. There was a fairly definitive statement from the APA (2012) on the 'Recognition of Psychotherapy Effectiveness':

> These large effects of psychotherapy are quite constant across most diagnostic conditions, with variations being more influenced by general severity than by particular diagnoses – That is, variations in outcome are more heavily influenced by patient characteristics e.g., chronicity, complexity, social support, and intensity – and by clinician and context factors than by particular diagnoses or specific treatment "brands".
>
> ... the results of psychotherapy tend to last longer and be less likely to require additional treatment courses than psychopharmacological treatments.
>
> ... for most psychological disorders, the evidence from rigorous clinical research studies has shown that a variety of psychotherapies are effective with children, adults, and older adults. Generally, these studies show what experts in the field consider large beneficial effects for psychotherapy in comparison to no treatment, confirming the efficacy of psychotherapy across diverse conditions and settings.
>
> ... comparisons of different forms of psychotherapy most often result in relatively nonsignificant difference, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that (1) most valid and structured psychotherapies are roughly equivalent in effectiveness and (2) patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific psychotherapy, affect the results.
>
> ... in studies measuring psychotherapy effectiveness, clients often report the benefits of treatment not only endure, but continue to improve following therapy completion as seen in larger effect sizes found at follow-up.
>
> ... the research evidence shows that psychotherapy is an effective treatment, with most clients/patients who are experiencing such conditions as depression and anxiety disorders attaining or returning to a level of functioning, after a relatively short course of treatment, that is typical of well-functioning individuals in the general population.

However, it has also been shown that some therapies are (in fact) better than others – especially for some things: e.g., CBT seems to be (for example) better than psychoanalysis for bulimic eating disorders (Poulson *et al*., 2014). Here, we need to mention something about the distinction between research on the *efficacy* of psychotherapies (which try to maintain the internal validity of studies, by keeping conditions – like random assignments, control conditions, therapists' training, and vetting participants – as similar as possible) and research on the *effectiveness* of psychotherapies, which try to maintain the external validity of differ-

8. **NICE Guidelines for Depression**: NG 222: 2022; NICE Guidelines for Anxiety Disorders QS 53/CG 22: 2014.

ent studies, by locating the treatment studies in similar clinics, for example, or whether the beneficial effects are sustained. Ideally, both apply.

> Data from both efficacy and effectiveness studies are key to a full understanding of the potential impact of a treatment. Once a treatment has been shown to be efficacious through multiple replications, the next step is to determine how well the treatment works in typical clinical practice. Evidence demonstrating that treatments evaluated under highly controlled research conditions (i.e., efficacy studies) can have a comparable clinical impact when delivered in regular clinical settings (i.e., effectiveness studies) provides essential support for the routine clinical use of such treatments. (Hunsley, Elliot & Therrien, 2013, p. 5)

Again and again, different therapies (or treatments) seem 'better' than others for certain problems or disorders, and – in certain cases – a combination of medication and psychological therapy seems to be more effective and/or efficacious. The above study (Hunsley, Elliot & Therrien, 2013) compared both efficacy studies and effectiveness studies for: depression, bipolar disorder, generalized anxiety disorder, social anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder, specific phobias, panic disorder, as well as coronary heart disease.

Somewhat less interesting is the fourth edition of a fairly definitive tome that calls itself, *A Guide to Treatments that Work*, (Nathan & Gorman, 2015). This considers a mass of outcome data and clinical trials, on both psychological and pharmaceutical treatments – again condition by condition – and uses various parameters to ascertain their efficacy and effectiveness.

WOOP-ing Along Successfully!

One fairly pragmatic technique that seems to be quite successful in many different domains – interpersonal, academic, health, professional, etc. – which used to be called 'Mental Contrasting with Implementation Intentions (MCII) and that has been reasonably well-researched (Oettingen, 2015; Oettingen *et al.*, 2015), is now given the acronym, 'WOOP': Wish – Outcome – Obstacle – Plan.

Health professionals trying to help people make effective changes in their lives might be interested to know the basics of 'WOOP'. To read the literature makes it sound a little like a magic bullet: but the acronym just helps to identify the Wish (where the person wants to go, or how they want to be), given the perceived present reality and thus helps identify the beginnings of the pathway to the Outcome; there is then the opportunity to clarify – and improve – one's expectations, especially about overcoming any Obstacles in the way; and that leads to the Plan!

There are many similar techniques (and acronyms) in management and motivational training, so it is not particularly surprising to see something like this finding its way into the field of psychotherapy. What is somewhat surprising is that Gabrielle Oettingen is Professor of Psychology at New York University, as well as the University of Hamburg, and that she also works with colleagues in the Department of Management in the prestigious London School of Economics. This is therefore an interestingly practical tool, hence – perhaps – its appeal.

The Great Divide

However, as one investigates further into the arena of what works and what doesn't in psychotherapy and counselling, one becomes

more and more aware of a 'Grand Canyon' or a 'Great Divide' that exists in psychology, psychotherapy and counselling (and other clinical disciplines) between the academic researchers, on the one side, and the clinical practitioners, on the other. This "Great Divide" (as it is known: Stiefel *et al.*, 2014) is between two quite different realities: so-called 'evidence-based practice' (EB) and 'clinical practice' (CP).

> [The negative reactions to EB] ... are indicating that the people who use this word have no idea of the real life issues a busy ... therapist encounters! What do these clean, artificial, randomly controlled trials with placebos tell us about the messiness only we as therapists see? *Nothing!* Such trials feel like rhetoric; bureaucratic exercises that don't add anything of importance. Further, they ignore context, they don't reflect multiple issues, they are not reproducible in our consulting rooms, and they reflect first-order, outdated practices in both therapy and research. (Ibid, p. 49)

So, there are four basic types of 'evidence' implicit here: (1) high-quality scientific research, which is replicable and which can provide *"practice advice and guidelines on the most effective ways of diagnosing and treating problems of a similar nature in carefully selected groups of people who meet certain criteria"* (Ibid) – essentially a randomised controlled trial, impossible for most clinicians; (2) multiple-sources of information, which go towards producing practice guidelines and protocols, assisting *"health care agencies to discharge their responsibilities in cost-effective ways and manage their liabilities ..."* (Ibid); (3) a considerable amount of practical clinical experience; and (4) (most importantly) 'evidence' stemming from direct client feedback (Williams, 1999, 2002). These four categories are broad and somewhat overlapping, but they are also fundamentally different and yet they complement each other. Much of science and research, especially in the field of psychology (study of the *psyche*), falls into the first two categories; yet the people doing hands-on therapy (*therapia* – healing) work in the field of psychotherapy & counselling have a totally different set of experiences and also a very different evidence-base (the second two categories). We all therefore have to decide which – and which combinations – work for us and our clients.

This brings us to a whole area of 'critique' (which I prefer to 'critical') of the field of psychotherapy and counselling. *What Works for Whom? A critical view of psychotherapy research*, was the title of a (1996) book by Anthony Roth and Peter Fonagy (of University College, London): a second edition came out in 2006. This was one of the first of many attempts to enter into – and sort out – the (almost deliberate) confusion of what is 'evidenced-based practice' and what has been so controlled – for sound research purposes – that it is now largely irrelevant to everyday clinical practice. The authors were very mindful of this gulf between research conditions and therapy in the real world: *"The challenge is to achieve practice that is rooted in empirical findings, but not circumscribed by them."*

However, what we all want – and need – is to discover ways that these "two houses divided" can come together. There is a recent movement towards establishing Clinical Practitioners Research Networks (CPRN) or Practice-based Research Networks (PBRN): both official (like the UK's National Institute for Health Research: Clinical Research Network, Mental Health [9] and the US Department of Health & Human Sciences' Agency for

9. **NIHR-CRN**: https://www.crn.nihr.ac.uk/mentalhealth/

Healthcare Research and Quality [10]) and more 'unofficial' collaborations between (say) universities and professional associations that collect studies in primary care and community settings. However, these bodies often face a number of challenges: including a basic lack of funding; networks must also make greater use of health information technology to solicit clinician involvement; identify and recruit potential subjects; and the ability to disseminate their key findings – a lot of extra work for already over-burdened health professionals. [11]

Personally, as a clinician, I feel it essential to keep reasonably up-to-date and informed by professional reading (journal articles, research studies, etc.). Our profession of psychotherapy is more of a 'craft' than a science, and we need to be constantly developing our skill-set: we can be informed by science and we can even inform science, by engaging in the dialogues, or publishing case studies or practice-based research. When addressing the need for Continuing Professional Development, subscription to a professional journal should be (almost) mandatory, as well as attending seminars and conferences. Luckily, nowadays, this is much easier (and cheaper) to do as there is a massive amount available through the internet.

Critical Psychotherapy & Counselling

This then leads us into an arena that is known as 'Critical Psychotherapy and Counselling'. In June 2015, at the Anna Freud Centre in London, there was a one-day conference 'event'. Speakers from different countries and different theoretical perspectives addressed questions about the provision of talking therapies in contemporary society and how therapeutic practice is affected – or not. They addressed various questions like:

- Is it important for psychotherapy & counselling to be 'critical', socially engaged, and/or even political?
- Do psychotherapists & counsellors do a disservice to their clients by not challenging present professional parameters?
- Do psychotherapy & counselling trainings actually discourage critical thought and free-thinking? Are they just churning out 'clones' able to do it 'this' way?
- Do present professional parameters promote an 'other-worldly' sense of psychotherapy distant from the patient/client's 'inner world'?
- What models of 'mental illness' and (especially) 'mental health' are appropriate for psychotherapy in the 21st century?

These are all fairly fundamental questions – and probably need to be addressed and answered regularly. A previous (2014) conference, *The Limbus Critical Psychotherapy Conference*: – "Challenging Cognitive Behavioural Therapies: The Overselling of CBT's evidence-base" has a post-conference website with download-able papers, which may be of interest [12]. And there is much more about

10. **AHRQ-PBRN**: https://pbrn.ahrq.gov/about
11. See **Calmbach *et al*., 2012**.
12. **Limbus Conference website**: Downloadable papers: www.limbus.org.uk/cbt/papers.html
    - Shedler (2010). The Efficacy of Psychodynamic Psychotherapy
    - Longmore & Worrell (2007). Do we need to challenge thoughts in Cognitive Behavioural Therapy?
    - Adams (2008). Naughty not N.I.C.E.: Implications for therapy and services
    - Ferraro (2015). Torture, Psychology & the Neoliberal State
    - Henrich, Heine & Norenzayan (2008). The Weirdest People in the World

'critical' psychotherapy out there – if you want to find it. I am not yet sure how useful the answers to some of these legitimate questions that have been raised are for us, practitioners, in the here-and-now with our clients. Personally, the word 'critical' has a slightly negative connotation, so I prefer the concept of 'critiquing' our profession.

A spin-off of this critical therapy 'movement' is the question of *"What is 'Real Therapy'?"* There seem to be an increasing number of 'threats' to 'real therapy' (Slaney, 2015) coming from:

- UK Governmental 'initiatives' like IAPT; and recently IAPT 'therapists' (or similar) being placed in Job Centres with the sole intention of getting people back to work.
- The current 'volunteering' system for trainees (to gain experience) and the 'intern' system for new graduates (ditto), which can extend into a sort of exploitation.
- The increasing state 'regulation' of the professions of psychotherapy & counselling, which may (or may not) develop into a 'decision-making' process of who can work and who cannot work in a particular profession or country.
- Professional associations in psychotherapy and counselling 'ducking' the quite serious issues of diversity and equality, as well as 'who judges whom' in issues of unethical behaviour and unprofessional conduct.
- The irrelevance of psychotherapy and counselling to the impact of austerity programmes on individuals and communities, and the 'blind-spot' about the psychological damage that these type of policies can incur.
- The impact of innovative (quick fix?) therapies that question traditional ideas of expertise and containment and produce 'solutions' (often with acronyms) that supposedly 'cure' several conditions in just a few sessions. This might work for some (a small %) who just need a bit of help or guidance, but it is not a 'cure-all'.
- The extent of bullying, harassment and intimidation that is sometimes found in both training and service organisations within the field of psychotherapy and counselling.
- The negative influence of 'Big Pharma' that tries to identify specific 'conditions' that can then be 'treated' pharmaceutically. People with problems – the ones that we see in our clinics – are just not like this. Any person suffering anxiety or depression (as well as many other conditions) is – more often than not – being negatively affected by almost overwhelming stressful life circumstances. We did not evolve to be able to cope with 21st century life-styles, plus global warming, plus CoVid, plus wars, and rising prices, etc.

If psychotherapists and counsellors are trying to work with such people within such confine-

- Richardson (1997). Fields of Play: Constructing an academic life
- Greenhalgh (2014). Evidence based medicine: a movement in crisis?
- Samuels & Veale (2007). Improving Access to Psychological Therapies: For and Against
- Westen, Novotny & Thompson-Brenner (2004). The Empirical Status of Empirically Supported Psychotherapies: Assumptions, Findings, and Reporting in Controlled Clinical Trials.
- Breen & Darlston Jones (2008) 'Moving Beyond the Enduring Dominance of Positivism in Psychological Research' 43rd Australian Psychological Society Annual Conference
- Dalal, F. (2015) 'Statistical Spin, Linguistic Obfuscation: The Art of Overselling the CBT Evidence Base' *Journal of Psychological Therapies in Primary Care*

ments and limitations, then – "what works for whom" is – perhaps – a very legitimate question: or rather – "what is supposed to work (and doesn't seem to) ... for them".

Social, Cultural, Political and Historical Issues

In a 2015 letter [13] in *The Guardian* newspaper, 442 psychotherapists, counsellors and academics condemned UK Conservative government plans as their 2015 budget included plans to provide online cognitive behavioural therapy to 40,000 employment and support allowance and jobseeker's allowance claimants and people on the Fit for Work programme, and to put IAPT therapists in more than 350 Jobcentres. Counsellors and psychotherapists in both the public and private sectors would therefore find themselves 'at the coalface', responding to the effects of the current 'austerity politics' on the emotional state of the nation. The previous five years had already seen a radical shift in the kinds of issues that generated distress in clients: increasing inequality and outright poverty; families forced to move against their wishes; and - perhaps most importantly – benefits claimants (including disabled and ill people) and those seeking work being subjected to a quite new intimidating kind of disciplinary regime: being coerced into having "Get Back to Work" 'therapy' is manifestly not therapy at all ... it is actually damaging and professionally unethical. Private psychotherapists and counsellors probably saw less of these social pressures, as such 'claimants' cannot usually afford to pay for therapy, yet they may be those most in need.

Similar strictures can often apply to therapy work with asylum seekers, refugees, economic migrants and illegal immigrants: these people have often been severely traumatised, both in their country of origin and also (possibly) by the rigours of the journey itself. They therefore need a special 'type' of therapy and (often) from someone who is familiar with their issues and even conversant with their language or country of origin. This is very rarely found (or provided) and this type of therapy work is also quite 'telling' on the therapist, as well (Azar, 2006).

This then takes us into the whole, very difficult, field of trans-generational trauma and how, who and when one can work with this (Fromm, 2012; Connolly, 2011). There is also a whole (new) field of psychohistory looking at collective trauma and other issues through the ages that often we (collectively) do not want to look at (Stein, 2007). Again, this sort of work raises the increasingly pertinent questions of: what works; how does one work; and what works for whom?

Psychotherapists and counsellors have historically been quite reticent in looking at some of these bigger cultural issues. Freud did not want to look at the possibility of familial sexual abuse; in the 1930s, the German and Austrian psychoanalysts (bar one: Wilhelm Reich) did not want to threaten their new-found status by taking-on German and Austrian Fascism; many professionals did not know how to work with (for example) survivors of the Holocaust; and many 'survivors' did not consider using psychotherapy to try to heal their trauma. In the 1970s and 1980s, it took psychotherapists, counsellors and social workers quite a long time to realise the enormity of the problems around childhood sexual abuse, even to the point of becoming over-enthusiastic and creating (possible) 'false memory' syndromes.

13. **Letter to *The Guardian***: http://www.theguardian.com/society/2015/apr/17/austerity-and-a-malign-benefits-regime-are-profoundly-damaging-mental-health

Even though war-trauma was described by Herodotus in 500 BCE, and even after the pioneering work of W.H.R. Rivers had identified 'shell shock' in WWI soldiers, it was not really until the needs / demands of the Vietnam War veterans, 50 years later, that 'post-traumatic stress' became properly identified and therapists began to find ways to work with this 'syndrome' quite successfully. Equally, there are many cultural 'norms' – as well as psychological inhibitions – that prevent people from seeking psychotherapy or counselling.[14] There is not much point in going further into these areas: I want to get back to the main theme: What actually works in psychotherapy!

Mindfulness Practice

One of the new phenomena in counselling & psychotherapy is the recent introduction of various forms of 'mindfulness', which have been shown to be reasonably effective – particularly for mild-to-moderate anxiety & depression. There are several different forms of mindfulness practice (body scan meditation; movement meditation; breathing space meditation; expanding awareness meditation; etc.) – and no one particular form seems to be better than any other (Alidina & Marshall, 2013). Certainly, since anxiety is mostly about what might happen next (and the consequences of what has just happened), the focusing on what you are both experiencing and feeling in this present moment creates an anxious-free space, and the practice of reconnecting with your body and feelings can also create a sense of peace and calm, possibly enhanced by greater insight, less digestive problems, better sleep, etc.

Mindfulness mediation is also a 2,500-year-old Buddhist practice, with a whole ethical system (right way of living) embedded into it (Hahn, 2008). Essentially, it is the practice of focussed self-awareness – of one's full (embodied & feeling) Self – in the moment (Bishop *et al.*, 2004). It seems to work very effectively for both therapists and clients (Carmody & Baer, 2008; Davis & Hayes, 2011) and is – increasingly – espoused by both CBT[15] and the more Humanistic and Integrative psychotherapies, as well as modern Buddhism. However, there are also some criticisms that the type of mindfulness practice that is being touted as the 'technique of the month' is in reality a very 'lite' form of the proper (and much deeper) Buddhist meditational practice.

> Does the contemporary notion of mindfulness have the same meaning as it does in the Buddhist Vipassana meditation I learned so long ago? It seems apparent from an examination of the mindfulness approaches, it does not. … The Buddhist approach to mindfulness is founded upon personal practice of meditation – not intellectual knowledge. When researchers and clinicians attempt to use the concepts without the foundation of personal practice, there are bound to be problems with their work. (Hendlin, 2016, pp. 36-37)

However, there is little doubt from both researchers and clinicians – as well as feedback from the clients – that the use of mindfulness in psychotherapy is both efficacious and effective, as well as being helpful. I find that a very good book that is often useful for clients who are starting out in mindfulness is Thich Nhat Hahn's *Peace is Every Step*[16] or Ram Dass' *Be*

14. See **Mojaverian *et al.*, 2012**; **Sheikh & Furnham, 2000**; **Vogel *et al.*, 2007**.
15. See **Kabat-Zinn, 2004, 2013, 2023**.
16. See **Thich Nhat Hahn, 1991**; also **2008**.

Here Now [17] – as well as his other many writings.

Why and How Therapy Works

We have been considering 'what' works in therapy, but we also might want to consider briefly 'why' therapy works: this is just one perspective – this is from neuroscience.

> The story of why psychotherapy works begins with the brain. We must understand how it evolved to learn, unlearn, and relearn. We have to understand the power of human relationships to regulate anxiety and stimulate learning, and that the way we interact with the world physically, emotionally, psychologically, and spiritually has been woven into our social brains. Finally, we must understand the role of stories and our ability to edit our own stories to change the patterns of our lives for the better. (Cozolino, 2015)

Actually, Cozolino, as well as other neuroscientists, are now able to inform us not only 'why' psychotherapy works, but we are also discovering much more about 'how' it works. It is not just a matter of: *"expressing the unexpressed, making the unconscious conscious and integrating thoughts and feelings."* ... because ... *"Language serves the integration of neural networks of emotion and cognition that supports emotional regulation and attachment. Putting feelings into words and constructing narratives of our experience make an invaluable contribution to a coherent sense of self."* (Ibid, p. 14).

We can therefore start to use techniques and interventions that assist this undoing process and re-doing, un-learning and re-learning, and the de-programming of the trauma process and hyperalert response. Cozolino also describes how ancient physiological responses, when confronted with high states of internal arousal, actually shut down the brain areas for expressive speech (i.e. we become 'tongue-tied' when talking to the boss; or 'speechless' with terror), in the same way that adrenaline (the main stress hormone) shuts down our digestive system (as you don't want to be digesting your own lunch when under the threat of becoming something else's lunch).

Whilst this may have been a really good primitive survival technique for our precursors in the African bush, our subsequent developments in language mean that this can now become a difficulty. As therapists, we cannot easily challenge the client's 'hyper-arousal' or their 'shut-down' into silence – as that may tip the balance and the client may flee. We need to accept their inhibitions and allow their arousal levels to calm down, back into what Pat Ogden (Ogden *et al.*, 2006) calls the "comfort zone", when the client relaxes a little and then can speak again (usually about the trauma), before we can continue with the 'talking therapy'. There has to be something of a 'dance' between therapist and client, and also a dance between arousal and relaxation within the client, that the therapist needs to be exquisitely aware of and work with this, rather than against it.

Stephen Porges, another neuroscientist, has demonstrated the importance of the body's Vagal system – which he refers to as the "social engagement system" – and this helps explain why we don't get better just by ourselves – essentially, we need contact with others so as to begin to self-regulate and heal. He, with his PolyVagal colleagues, has been doing a lot of excellent work in the field of healing people with trauma: a nice instance of how

17. See **Ram Dass, 1971**.

science can inform therapy.[18]. It is perhaps also worth mentioning here the work of Bessel van der Kolk, yet another neuroscientist, who is now an 'expert' in the healing of trauma.[19] His research indicates the physiological necessity of a traumatised person being in a place of safety, so that their amygdala can begin to 'relax' before the healing process can start: the healing of trauma happens well below the level of cognition.

Porges (2009, 2011), Wagner (2016) and Dana (2018) all describe, quite effectively, how different 'systems' within the body can be affected by states of arousal and also about how to work with these effectively. Porges' Polyvagal theory specifies the functioning of two distinct branches of the vagus (or tenth cranial) nerve: this is a significant part (longest nerve) of the sympathetic half of the ANS and also forms part of the motor aspects of the parasympathetic part of the autonomic nervous system. These two branches of the vagal nerve serve different evolutionary stress responses in mammals: the more primitive branch elicits immobilization (e.g., the 'freeze' response, or 'feigning' death), whereas the more evolved branch is linked to social communication and self-soothing behaviours. These functions follow a phylogenetic hierarchy, where the most primitive systems are activated only when the more evolved functions fail. These neural pathways regulate autonomic states and the expression of emotional and social behaviour. Thus, according to this theory, one's physiological state dictates the range of behaviours and psychological experience.

The polyvagal theory has many implications for the study of stress, emotion, and social behaviour, which has traditionally utilized more peripheral indices of arousal, such as heart rate and cortisol level. The measurement of vagal tonus in humans has become a novel index of stress vulnerability and reactivity in many studies of populations with affective disorders, such as children with behavioural problems, and even those suffering from borderline personality disorder.

However, what health professionals often overlook is that 'anxiety' and/or 'depression' are not necessary "illnesses". In (perhaps) 95% of clients/patients who present with anxiety and/or depression, these are "symptoms" of almost over-whelming life stress. There is actually nothing 'wrong' with the person; and they have not done anything 'wrong'. What has happened it that this 'wrong' (stressful) thing happened; and then that; and then this; and so on. When this is put to a client, they almost immediately: (a) agree and are able to identify the 'this' and 'that' and all the 'other' stressful life events; and (b) they experience a massive sense of relief.

This is – of course – a pragmatic application of Holmes & Rahe's (1967) research. They demonstrated that an accumulation of different stressful life events within a relatively short period (1.5 to 2 years) was a fairly reliable predicator of illness: often mental health issues, as well as psychosomatic symptoms. Working from the patient/client's 'lived experience' is – of course – much more effective than a 'label' or a 'diagnosis' as the 'problem is more accurately identified and then a variety of appropriate psychotherapeutic techniques can be applied – hopefully more successfully than 'just' medication and/or a step-by-step therapy. The physiological component – an overload of the stress reaction system ('fight-flight-fright'), the sympathetic half of the person's autonomic nervous system (ANS) –

18. See **Porges, 2009, 2011 & 2021**; **Wagner, 2016**; **Dana, 2018**.
19. See **van der Kolk, 2015**.

then impacts on a person's natural 'balance' which – for most animals – is in a ratio of about 1:5 (level of Sympathetic to Parasympathetic activity); however, the human 'animal' (especially in Western countries) is operating on a (something like) 5:1 ratio: the wrong way round, so that we are about 25 times more stressed than any other animal on the planet, which puts us very close to the 'edge' of our evolutionary potential. [20] We can see what happens to other species when they get overstressed, but we seem to be unable to see this in ourselves.

Another significant part of these physiological interactions is the stimulation of a number of chemical (peptide) receptors – peptides are single molecules made up of strings of amino acids, arranged rather like beads on a necklace. About 85-95% of the neuropeptide receptors are found in the emotional centres of the brain's limbic system. [21]

> Emotional states or moods are produced by the various neuropeptide ligands, and what we experience as an emotion or a feeling is also a mechanism for activating a particular neuronal circuit – simultaneously throughout the brain and body – which generates a behavior. (p. 201).

Pert believes that there is probably one kind of peptide (and there are about 660 'peptides' in total) for each possible emotion: just as endorphins are the mechanisms for bliss, and oxytocin is a part of the hormonal mechanism for bonding, as well as breast-feeding. [22] Emotional states or moods are therefore also produced by the various neuropeptides, and what we experience as an emotion or a feeling is also a chemical mechanism for activating a particular neuronal circuit— simultaneously throughout the brain and body – which then generates a particular behaviour. Endorphins, a group of opioid hormones that produce an analgesic effect, are quite well-known. Oxytocin is the hormone involved in bonding, sex, childbirth, and breast-feeding, as well as in relaxation and feelings of calm. It is the virtual mirror image of the stress hormone (adrenaline / epinephrine), which triggers the "fight or flight" systems in the body.

New research findings, as well as the potentially beneficial applications of this hormone in reducing anxiety states, stress, addictions, and problems of childbirth, are not only fascinating, but of great significance to all our lives – and especially to our work as therapists. We can thus – potentially – influence what happens in the client's body in various ways: e.g., by visualizing an increased flow of blood into a body part to increase the flow of nutrients to that area; or using some form of therapeutic massage or encouraging self-massage by the client in certain ways that can help stabilize the client's emotions.

All this indicates that a 'good' therapist needs – not only to have a considerable level of knowledge – but also a considerable level of 'skill', in order to be aware of these somewhat more subtle aspects of the client's physiology, as well as their psychology, during the continually moving moments of a therapy session. Psychotherapy is therefore much more perhaps of a craft, than an academic science [23] – and these skills need to be developed and 'honed' to a fine degree through: professional practice; good line-management & supervi-

20. See **Young, 2008**.
21. See **Pert, 1997**.
22. See **Moberg, 2003**.
23. See **Young & Heller, 2000**.

sion; proper & individual 'outcome' monitoring & research; a 'required' level of continuing professional development (CPD); regular re-accreditation; and a culture of 'life-long learning'.

Anyway, to conclude this section, if you are working with traumatised clients – please remember that trauma is stored in the body as well as the mind, so perhaps you need to read about the work of people like the above as well as Babette Rothschild (2000), Peter Levine (2015), Judith Herman (2015) & Gabor Maté (2022).

If you take this theme just a little further and start to examine – and perhaps even to discover – **how and why** therapy works with your clients, then perhaps you will be writing future articles and books on this topic.

Feedback Informed Treatment (FIT)

Scott Miller (see above) and others set up the 'International Center for Clinical Excellence' (ICCE) to discover 'What Works in Therapy'. Their manual consists of a guide (in six parts) covering the most important information for practitioners and agencies implementing FIT. This is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioural health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery. It also involves the integration of the best available research … and monitoring of one's patient / client progress (and of changes in the patient's circumstances – e.g., job, loss, major illness) that may suggest the need to adjust the type or course of treatment (APA, 2006).

1 *Significant Research Findings in Behavioural Health Outcomes:*

They looked first at 'Behavioural Health Outcomes', which concludes: (a) the average treated person is better off than 80% of those without the benefit of treatment; (b) psychotherapy is cost-effective; (c) therapy works largely because of general factors that are expressed in variable proportions through the interactions between clinicians and consumers; (d) there are 'client / extra-therapeutic factors', which account for about 80-87% of the variability in scores between treated and untreated clients; and then (e) a much smaller proportion of therapeutic factors that include: 'treatment effects' which represent a broad class of factors that are considered relevant to the influence of treatment. It is estimated that 'treatment' in total only contributes about 13-20% to the overall outcome of therapy: this total includes alliance effects (5-8%); model/technique effects (1%); expectancy, placebo and allegiance effects (4%); and therapist effects (4-9%).

The next two areas that form the foundation of what works in therapy are: (A) evidence of the role of routine and on-going client feedback in improving outcomes; and (B) predictors of outcome. Each area is central not only to improving outcomes, but also in elevating consumer confidence, ensuring the long-term viability of psychotherapy as a treatment option and creating greater accountability, stewardship and return on mental health service investments. There is a worldwide shift toward outcomes that are not specific to mental health. It is essential that clinicians follow this lead and demonstrate – through reliable and valid methods – a greater degree of accountability for the value of psychotherapy.

A. Evidence of the Role of Routine and Ongoing Feedback in Improving Outcomes.

The best available research reveals that the use of routine and on-going client feedback provides practitioners, and the field, with a simple, practical, and meaningful method for documenting the usefulness of treatment. Seeking and obtaining valid, reliable, and feasible feedback from clients (consumers) regarding the therapeutic alliance and outcome, as much as doubles the effect size of treatment; cuts dropout rates in half; and decreases the risk of deterioration by about 33%; reduces hospitalization and shortens length of stay by about 66%; and significantly reduces the cost of care (compared to non-feedback groups, which increased in cost). Additional evidence indicates that regular, session-by-session feedback, as opposed to less frequent intervals, i.e., every third session, pre- and post-services, etc.[24] is more effective in improving outcome and reducing dropouts. As the APA Task Force on Evidence-Based Practice (2006) concludes, *"providing clinicians with real-time patient feedback to benchmark progress in treatment and clinical support tools to adjust treatment as needed"* is one of the *"most pressing research needs"* (p. 278).

B. Predicators of Outcome

The following factors have been shown to be consistent, robust predicators of an eventual positive outcome: (a) Short duration of therapy, with some positive changes; (b) Early client change – the 'dose-effect relationship' (whereby 30% of clients experience an improvement by 2nd session and 60-65% by session seven; 70-75% within 6 months; and about 85% by one year); (c) Consumer / client rating of the therapeutic alliance is a better predictor of positive outcome than the therapist's; (d) Level of consumer / client engagement is one of the most determinant predictors of outcomes;[25] (e) Improvement in the alliance over the course of treatment: client-therapist alliances that strengthen and improve from intake to termination tend to yield better outcomes;[26] (f) The client's level of distress at the start of therapy - more so than diagnosis, the severity of the client's distress at intake predicts eventual outcome. Clients with higher levels of distress are more likely to show measured benefit from treatment than those with lower levels or those who present as non-distressed;[27] (g) Clinician's allegiance to their choice of treatment approach: While research shows that there are few, if any, meaningful differences in outcome among treatment approaches, research documents that clinicians must have faith in the restorative power of therapy as a healing ritual. Furthermore, it is important that clinicians have therapeutic rationales, employ strategies consistent with those rationales, and believe in their approaches.[28]

2 *The Therapeutic Alliance*

The therapeutic alliance is one of the main factors that does seem to 'work' in psycho-

24. See **Warren *et al.*, 2010**.
25. See **Orlinsky *et al.*, 2004**.
26. See **Anker *et al.*, 2009**.
27. See **Duncan *et al.*, 2010**.
28. See **Hubble *et al.*, 2010**.

therapy and counselling. This 'alliance' refers to the quality and strength of the collaborative relationship between the client and the therapist.[29] The alliance is comprised of four empirically established components: (1) Agreement on the goals, meaning, or purpose of the treatment; (2) Agreement on the means and methods used; (3) Agreement on the therapist's role (including being perceived as warm, empathic, and genuine; and (4) Accommodating the client's preferences. Over 1,100 separate research findings document the importance of the therapeutic alliance in any successful therapy, making it one of the most evidence-based concepts in psychotherapy.[30] Significant findings from this area of research are detailed in this next section:

a) **The therapeutic alliance makes substantial and consistent contributions to client success across nearly all different types of psychotherapy**. Over 20 meta-analyses have demonstrated the impact of the therapeutic alliance on treatment outcomes.[31] The relationship and alliance act in concert with treatment methods, client characteristics, and clinician qualities in determining effectiveness. The alliance accounts for between five to nine times more of the outcome of treatment than the model or technique.[32]

b) **Next to the level of client's functioning at intake, the client's rating of the alliance is the best predictor of treatment outcome and is more highly correlated with outcome than clinician ratings**. The partnership between the therapist and client, as rated by the client, is a consistent predictor of eventual treatment outcome and more reliable than therapist ratings.[33] Some therapists form better alliances with clients and achieve better outcomes. In contrast, clients of therapists with weaker alliances tend to drop out at higher rates and experience poorer outcomes.

c) **A significant portion of the variability in outcome between clinicians is due to differences in the therapeutic alliance**. Variability between clients is to be expected with regard to client ratings of the alliance. However, some therapists consistently form better alliances with clients and variability in the alliance accounts for a large portion of the differences in outcomes between therapists.[34]

d) **Monitoring the alliance allows clinicians to identify and correct problems with engagement and reduce early dropout or risk of negative outcome**. Routine and ongoing monitoring of the alliance through real-time client feedback processes helps to both identify potential ruptures and create opportunities for clinicians to take corrective steps.[35] In addition, improvements in the alliance (intake to termination) are associated with better outcomes and lower dropout rates.[36]

All these points indicate areas of possible improvement, but – in reality – 'improvements'

29. See **Norcross, 2010**.
30. See **Norcross, 2011**; **Orlinsky *et al.*, 2004**.
31. See **Horvath & Simmons, 1991**.
32. See **Martin *et al.*, 2000**.
33. See **Norcross, 2010**.
34. See **Baldwin *et al.*, 2007**; **Anker *et al.*, 2009 & 2010**.
35. See **Duncan *et al.*, 2010**; **Harmon *et al.*, 2005**.
36. See **Lambert, 2010**; **Miller *et al.*, 2007**.

in the therapeutic alliance are totally in the hands of the therapist, or perhaps rather in the personality of the therapist. As in all heartfelt relationships, there needs to be a range of 'good' human qualities such as: compassion, openness, empathy, genuineness, understanding, equality, compatibility, teamwork, good communication, patience, honesty, trust, responsibility, humour, respect, love, etc. If these are not already inherent in the therapist, then they can be learnt and then modelled, however these qualities do not usually form any part of any psychotherapeutic assessment or of any training programme, irrespective of the modality. These are essentially human qualities; they can possibly be measured; maybe they can also be acquired; they are not easily 'taught'.

How a Therapist Can Get Better

Most therapists aspire to get better at what they do. However, research has shown that personal therapy has nothing to do with their outcomes; there are no therapeutic approaches, strategies or interventions that have been shown to be better than any other; professional training and discipline do not matter much to outcomes; there is no evidence that shows that continuing professional education will improve effectiveness; and (although it defies common sense) clinical experience does not necessarily improve outcomes either. So, what does 'professional development' really mean and how do we accomplish it?

Barry Duncan (2014) asserts that 'getting better' at psychotherapy requires therapists to dedicate themselves to two key tasks: (a) obtaining systematic client feedback; and (b) taking charge of their own development as a therapist. He describes his 'Partners for Change Outcome Management System' (PCOMS), which provides systematic feedback from clients thereby enabling therapists to identify and target those clients who aren't responding to traditional treatment before they drop out. He examines the common factors inherent to all successful therapies, and details the importance of the therapeutic alliance as the foundation of effective therapy. He encourages all therapists to expand their theoretical breadth, think deeply about the lessons that they learn from their clients, and integrate these lessons into their professional practice.

Barry Duncan and Scott Miller are co-founders of the *Institute for the Study of Therapeutic Change*. And so, we come back right to the 'common factors' theory. They developed the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) as clinical tools to encourage therapists to discuss openly the benefits of the sessions and then to 'fit' their professional services to the needs of and benefits for their clients.

However, I think that they may have missed out on the need for clinicians and practitioners to stay in touch with and up-to-date with developments in professional issues and research. The whole purpose of all this – of course – is to improve one's actual therapeutic work, as much as is possible for a busy clinician. This means 'assuming' – contrary perhaps to what you were told – that your original training had certain significant deficits and also that the 'field' of psychotherapy and counselling is constantly changing and evolving: so, if you don't "go with the current flow", you might just end up in an inconsequential back-water with stagnant concepts and techniques – irrespective of the 'quality' (or limitations) of your original training. Some of this implies that therapists (should or do) keep a regular track of the 'outcomes' of their therapy with their clients. There are a variety of outcome measures used in the UK National Health Service (NHS) and the various Employee Assistant

Provider (EAP) companies that tend to use the CORE-IMS system).[37] However, in order to be a success, it means that the therapist must administer the outcome measure and record the results regularly.

What Does Not Work

It is fairly well-known and generally accepted that 'normal' one-to-one counselling & psychotherapy does not work very well for the following clints or in the following circumstances:

- People with a severe mental condition that affects their ability to make relationships, to concentrate and to attend regularly. Examples can include severe depression, psychotic illness, personality disorders, etc.
- People who are currently engaged in: self-destructive behaviours; prolonged substance abuse; alcohol abuse; eating disorders, etc.
- People with severe mental disabilities or learning disorders, etc.
- People with a history of violence, or with severe post-traumatic stress disorders, etc.
- People with a poor understanding of the therapist's language, etc.
- People from a very different background or culture, etc.

These types of clients usually do much better working within a specialized team approach, or in residential setting, or with specialist facilities, or working with a therapist who has had specialized training and/or developed specialized expertise – and then counselling and psychotherapy *in those circumstances* can be appropriate for them.

It is therefore very important for a therapist to know – and to work within – their (our) own personal & professional limitations. We need – as professionals – to be humble; we need to know what we don't know and be able to say, quickly and easily, *"That is something that I am not familiar with; however, you could try ... there ..."*. We need to know what we are good at and also what we don't know.

So, what else doesn't work? So, there are also several things that really don't work very well in counselling and psychotherapy:

- **Stitcking** too rigidly to the method that you have been taught: this is – no doubt – a very good basis for therapeutic work, but it probably (almost certainly) isn't enough, or suitable for every situation, or for every client;
- **Not**: ... keeping proper notes and records; ... getting enough supervision; ... obtaining enough CPD; ... doing additional reading; ... attending conferences; ... writing papers; ... engaging with other peer professionals; etc., etc.
- **Your Personal Needs** getting in the way of the client's needs or process: your regular hours, holiday times, frequency of

37. **CORE-IMS** (**Information Management System**): www.coreims.co.uk. This is a system of client self-report questionnaire that is designed to be administered before, during and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions: ■ Subjective well-being; ■ Problems/symptoms; ■ Life functioning; ■ Risk/harm. There is also a Therapy Assessment Form and an End of Therapy form. There are currently over 250 CORE PC Users including: ■ over 40 Primary care services ■ 40 Secondary & Tertiary Care services ■ 30 Workplace services ■ 80 Voluntary sector services ■ 30 University services ■ 10 Private services. Using this system can (a) measure the outcome of a particular therapist's clients; or (b) compare therapists within the same service.

sessions, fee structure, etc. all need to be (possibly) a bit flexible if you are dealing with a fairly mixed population of 'people';

- **Counter-transference**: if something in the client work "triggers" *your* 'stuff', you need to take care of it separately; so, beware the 'daemon' of beware counter-transference – it can sneak up on you and bite (!);
- **Professional attitudes** ... of pride or superiority or arrogance; of thinking that you know better; of thinking you can 'help' or 'save' this person; of thinking that your 'way' (method, style) is good, better, best; of thinking that just because you have been trained, qualified, accredited, then that is **It**; etc. and so forth – so, beware "hubris";
- **A Lack of Introspection**: you could do worse than remember Socrates: *"The unexamined life is not worth living."*

What also potentially doesn't work – and therefore we need to be particularly cautious about these possibilities – are:

- **Working with clients in areas that we are not personally familiar with**: e.g., (possibly) trans-gender issues; trans-cultural issues; childhood sexual abuse; etc.
- **Working with clients from backgrounds that we are not personally familiar with**: e.g., language differences; social & cultural differences; ethnic differences; prisoners; refugee & asylum seekers; etc.
- **Trying to be "helpful" to your clients** – because this is possibly more of ***your*** agenda than the client's – and it often doesn't work anyway: people have to learn how to help themselves better (Casement, 2014).
- **Not doing a proper 'risk assessment'** – especially if there is at least one 'red light', usually quite early one in the sessions: e.g., people with personality disorders do not make particularly good clients and often drop out before any significant change has happened.[38]
- **Not reading books like**: *The Mirror Crack'd – When Good Enough Therapy Goes Wrong and other cautionary tales for humanistic practitioners* (Kerns, 2007); or *The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients* (Yalom, 2003).
- **Not being aware of any possible adverse effects**: e.g., AdEPT → Supporting Safe Therapy.[39][40][41]
- **Ignoring / overlooking a particular client's particular needs or vulnerabilities**:[42] as you can – sometimes – actually do harm by not responding to them properly or ignoring their sensibilities.[43]

What Else Does Not Work in Therapy

This section focuses on what else does not work in therapy by addressing two prima-

38. **Therapeutic Risk Assessments**: See: www.bacp.co.uk/ethical_framework/good_standard.php; www.lifeforce-centre.co.uk/downloads/level4_yr2/session11/suicidal_client.pdf; www.therapytoday.net/article/show/1016/personal-safety-do-counsellors-care.
39. **University of Sheffield**: www.sheffield.ac.uk/news/nr/preventing-adverse-effects-of-psychological-therapies-1.376074 ⇒ Supporting Safe Therapy: www.supportingsafetherapy.org/
40. See: **Young, 2014**.
41. See also **Barlow, 2010**.
42. **Populations with Special Needs**: www.emc.ornl.gov/publications/PDF/Population_Special_Needs.pdf
43. See: **Ungar, 2015**; **Wolfson *et al.*, 2009**.

ry areas: **(1)** The lack of overall improvement in therapy outcomes, dating back to the first meta-analytic studies in the 1970s; and **(2)** A list of non-predictors and weak predictors of outcome.

1 *The Lack of Overall Improvement in the Effectiveness of Therapy*

Available research points to the reasons why the effectiveness of psychological treatments has not improved appreciably over the last three decades.

- **The emphasis on treatment models in professional discourse and training**: Though popular, there are actually very few if any meaningful differences in outcomes between different competing approaches – especially when the following factors are taken into account:

  Equal comparison conditions between bona fide approaches intended to be therapeutic. Bona-fide approaches are defined as treatments that are: **(1)** intended to be therapeutic (having a theoretical base and associated techniques); **(2)** considered viable by the psychotherapeutic community (e.g., through professional books or manuals); **(3)** delivered by trained therapists; and **(4)** containing ingredients common to all legitimate psychotherapies (e.g., a therapeutic relationship). In summary, when treatment conditions are equal, there are no discernible differences between bona-fide treatment approaches.[44]

  The statistical strength of meta-analytic studies as compared to single studies: Meta-analyses are a method of pooling together numerous studies with varying methodologies, sample sizes, and treatment approaches, all of which improves statistical power, flexibility, and generalizability compared to single studies. Numerous meta-analyses find no difference in effect between bona fide treatment approaches. To date, no differences in outcome have been found between different treatment approaches for psychotherapy in general; depression; PTSD; alcohol use disorders; and the four most common diagnoses in children and youth (depression, ADHD, anxiety, and conduct disorder). Despite claims that certain methods are superior to others, or that evidence-based practice is defined by specific treatments for specific diagnoses, meta-analytic studies fail to support such claims. Furthermore, any differences between approaches reported in specific studies do not exceed what would be expected by chance. The failure to find any difference in effect between competing treatment is referred to as "The Dodo Verdict," an expression first coined by psychologist, Saul Rozenzweig, who borrowed a line of text from Alice's Adventures in Wonderland to summarize the evidence regarding differential efficacy: *"All have won, and therefore all deserve prizes."*[45]

- **The failure to address dropouts in psychotherapy**: Research to date suggests that premature termination or dropout – the unilateral decision by clients to end therapy – averages about 47%.[46] For children and adolescents, the range

44. See **Anderson *et al.*, 2010**; **Benish *et al.*, 2008**; **Frank & Frank, 1991**; **Imel & Wampold, 2008**; **Wampold, 2007**; **Wampold *et al.*, 1997**.
45. See **Wampold, 2001**.
46. See **Wierzbicki & Pekarik, 1993**.

varies from 28% to 85%.[47] Clinicians, it turns out, achieve solid outcomes with clients who stay, but too many decide early to discontinue services. Even with well-trained and supervised clinicians, a significant percentage (30% to 50%) of clients do not benefit from therapy. The deterioration rate among adult clients ranges between 5% and 10%. Regarding children and adolescents, rates of deterioration vary between 12% and 20%.[48] It is estimated that the clients who do not benefit or deteriorate while in psychotherapy are responsible for 60–70% of the total expenditures in the health care system.[49] Moreover, clinicians routinely fail to identify clients who are not progressing, deteriorating, and at most risk of dropout and negative outcome.[50] Conversely, clinicians who have access to outcomes data can better identify clients who are not improving or getting worse and respond to those clients, thereby reducing the risk of dropout and negative outcome.[51]

- **Substantial variations in outcomes between clinicians with similar training and experience**: In practice settings, some psychotherapists consistently achieve better outcomes than others, regardless of the psychiatric diagnoses, age, developmental stage, medication status, or severity of the people they work with, across a range of patients.[52] Research findings indicate that clients of the most effective therapists improve at a rate at least 50% higher and drop out at a rate at least 50% lower than clients who work with less effective therapists.[53] The latest research indicates that 97% of the difference in outcome between therapists is attributable to differences in their ability to form alliances with clients.[54] Such findings indicate that the most effective therapists work harder than their counterparts at seeking and maintaining client engagement, as well as invest more time, energy, and resources into improving their craft.[55] Research consistently shows that the best predictor of engagement in psychological services is the client's rating of the therapeutic alliance.[56]
- **Therapists' lack of knowledge regarding their overall rate of effectiveness and the tendency of average clinicians to overestimate**: The majority of therapists have never measured their efficacy or effectiveness and therefore do not know how effective they are.[57] Naturally, it is impossible for clinicians to know if they are improving if they do not know their level of effectiveness. Additionally, therapists are not immune to a self-assessment bias in terms of comparing their own skills with those of their colleagues and in estimating the improvement or deterioration rates like-

47. See **Garcia & Weisz, 2002**; **Kazdin, 1996**; **Hansen *et al.*, 2002**; **Lambert & Ogden, 2004**.
48. See **Warren *et al.*, 2010**.
49. See **Miller, 2011**.
50. See **Hannan *et al.*, 2005**.
51. See **Lambert, 2010**; **Wampold & Brown, 2005**.
52. See **Brown *et al.*, 2005**; **Wampold & Brown, 2005**.
53. See **Wampold & Brown, 2005**.
54. See **Baldwin, Wampold & Imel, 2007**.
55. See **Hubble *et al.*, 2010**.
56. See **Batchelor & Horvath, 1999**.
57. See **Hansen *et al.*, 2002**; **Sapyta *et al.*, 2005**.

ly to occur with their clients.[58] Others found that therapists on average rated their overall clinical skills and effectiveness at the 80th percentile – a statistical impossibility.[59] Even worse, less than 4% considered themselves average and not a single person in the study rated his or her performance below average. The issue of therapists overestimating their personal effectiveness puts clients at risk for higher rates of dropout and negative outcome.

- **Clinician effectiveness tends to plateau over time in the absence of concerted efforts to improve it**: During their careers, clinicians acclimate to their settings, rely more on specific methods and strategies with which they are trained or are more comfortable, and become more confident in what they believe to be true about their clientele. Although these and other clinician factors may benefit specific clients in specific situations, they more often contribute to a plateauing of clinician effectiveness. Clinicians need to establish personal baselines of effectiveness and employ reliable and valid methods to monitor and track client feedback in relation to outcomes and the alliance to improve on those baselines.

There are also – some – valid reasons why someone in therapy might not get better – despite your best professional efforts. However, some of these points tend to put part of the onus for the failure of the therapy on to the patient / client and should therefore be considered only very cautiously:[60]

1. Being the 'wrong' therapist for that particular client.
2. Not identifying clearly enough the goals of therapy.
3. Are our interventions accessible to the patient / client – or are we "going over their heads", or not being realistic about their personal situation?
4. Is there something about the patient / client that we don't really like?
5. Are we being patient enough with the patient / client? Maybe *they* don't fit into *our* model of being a 'good enough' client or making 'good enough' progress.
6. The patient has: … a fear of judgment; … a fear of rejection; … a fear of assuming greater responsibility; … or a fear of intimacy: that may prevent *them* responding to our particular style of therapy, or *us* as a person.

2 *Non-predictors and/or Weak or Absent Predictors of Outcomes*

Myriad studies over the last three decades have identified a number of other variables that have little or no correlation with the actual outcome of treatment, including:

- Clients' age, gender, diagnosis, and previous treatment history[61]
- Clinician age, gender, years of experience, professional discipline, degree, training, licensure, theoretical orientation, amount of supervision, personal therapy, specific or general competence, and use of evidence-based practices[62]

58. See **Dew & Reimer, 2001**; **Lambert, 2010**.
59. See **Walfish, McAllister & Lambert, 2010**.
60. See **Elvira G. Aletta blog**: www.psychcentral.com/blog/archives/2011/03/16/10-reasons-why-someone-in-therapy-may-not-be-getting-better/
61. See **Wampold & Brown, 2005**.
62. See **Beutler *et al.*, 2004**; **Hubble *et al.*, 2010**; **Nyman *et al.*, 2010**; **Miller *et al.*, 2005**; **Wampold & Brown, 2005**.

- Model/techniques of therapy that don't affect outcome [63]
- Matching therapy to diagnosis [64]
- Adherence/fidelity/competence to a particular treatment approach. [65]

There are also – some – valid reasons why someone in therapy might not get better – despite the therapist's best efforts. However, some of these critiques tend to put part of the onus for the failure of the therapy on to the patient / client and should therefore be considered only very cautiously: [66]

1. Being the wrong therapist for that particular client.
2. Not identifying clearly enough the goals of therapy.
3. Are our interventions accessible to the patient / client – or are we "going over their heads", or not being realistic about their personal situation?
4. Is there something about the patient / client that we don't really like?
5. Are we being patient enough with the patient / client? Maybe they don't fit into our model of being a 'good enough' client or making 'good enough' progress.
6. The patient has: … a fear of judgment; … a fear of rejection; … a fear of assuming greater responsibility; … or a fear of intimacy: that may prevent them responding to our particular style of therapy, or us as a person.

There are however some therapists who unconsciously do harm, and we – as therapists – need to make sure that we are not one of them. [67] In another study, 28% of psychologists were found to be unaware that there were any negative effects in psychotherapy. [68]

> *"Theoretically, it makes sense that if we're going to look at a list of treatments that are effective, then it makes sense to look at treatments that could potentially be harmful."*

Therapist 'Drift'

Professor Glenn Waller, Head of Psychology at the University of Sheffield, presented a talk for the Scottish Division of Clinical Psychology about *'Therapist Drift': Why well-meaning clinicians mess up therapy (and how not to)*. [69] Therapist 'drift' is a topic that forces therapists to ask difficult 15 questions like, *"Am I truly helping people? Am I practising what I was taught (or learned) to be effective?"*; etc. There is evidence, he says, that high levels of empathy can be linked to poorer outcomes for patients; however, evidence also shows that therapist resilience leads to better patient outcomes; therefore, the therapeutic alliance is necessary, but not sufficient for patients' progress. Prof. Waller also pointed out that behavioural change builds the therapeutic alliance, and not visa-versa, as – apparently – patients value therapists' technical skills more than – or at least as well as – their interpersonal qualities. Therapists' anxiety about possibly distressing people and making things worse leads to

63. See **Benish *et al.*, 2008**; **Imel & Wampold, 2008**; **Miller *et al.*, 2008**; **Wampold *et al.*, 1997**; **Wampold *et al.*, 2002**.
64. See **Wampold, 2001**.
65. See **Duncan & Miller, 2005**; **Webb *et al.*, 2010**.
66. See **Elvira G. Aletta blog**: www.psychcentral.com/blog/archives/2011/03/16/10-reasons-why-someone-in-therapy-maynot-be-getting-better/
67. See **Jarrett, 2008**; **Rhule, 2005**.
68. See **Boisvert & Faust, 2006**.
69. See **Wall, 2017**.

their engagement in safety behaviours, such as avoidance of applying proven therapeutic techniques (e.g. exposure behavioural activation). Apparently only about 10% of clinicians routinely consult and read evidence-based manuals; and there is evidence that clinical judgement, length of times since qualification, experience and training do not lead to better predictions about what to do clinically. Some of the things that he recommended for therapists are:

- **Reflect and review** what they know works and what doesn't.
- **Psychological Education**: i.e., read the evidence-based manuals.
- **Monitor Progress**: making a checklist of techniques, skills and meta-competencies that are used, looking at and comparing outcomes over time periods.
- **Challenging Thought Forms**: Being aware of our own beliefs, schemas, and assumptions and examining them critically.
- **Changing Behaviours**: Testing out your beliefs using behavioural experiments: engaging in exposure; practising with supervision.
- **Reviewing**: using the outcomes; getting feedback; both when therapy has gone well and when it hasn't.

However, all this could be applied to any situation; to any level of clinical psychology, psychotherapy and counselling; and to any therapeutic modality; essentially, it boils down to ensuring that one keeps up to date, reviewing one's practice, doing some outcome research, and using acceptable (evidence-based) methods.

There are – as well – a number of psychological techniques or interventions that some therapists use, from time to time, with some patients or clients, but not necessarily with all. Some of these come from different methods or modalities; and different (often well-qualified) 'experts' promote others; but there is also little compelling evidence that these interventions always "work".

Amongst these interventions, some of the better known ones can be mentioned here: 'a relational object'; 'paradoxical intervention' or 'reverse psychology' [70]; Gestalt's 'empty chair' [71]; the 'miracle question' [72]; 'voice dialogue' [73]; 'hunger illusion' [74]; 'head-on collision' [75]; 'transference interpretation' [76]; 'sand-play' for children [77]; and so forth.

Whilst some of these techniques come from well-established and well-evidenced psychotherapies and counselling modalities, the techniques themselves can often be quite successful with some patients / clients on some occasions; a lot will also depend on the skill of the therapist as to know how, and when, and if, these might work. We know that these can work with some people, some of the time: but, really, that's all. Of course, some of the effectiveness of the functioning depends on the client as well: they should be encouraged to say whether this or that techniques works for them, or not.

70. See **Cory, 2012**.
71 See **Perls, 1992**.
72. See **Metcalf, 2007**.
73. See **Stone & Winkelman, 1988**.
74. See **Weinberg, 1996**.
75. See **Johansson *et al.*, 2014**.
76. See **Gabbard, 2010**.
77. See **Kalff, 1980**.

Therapies That Can Even Harm

There have also been a number of studies that 'claim' to have identified types of psychotherapy that either **do not work**, or that may even **cause harm**:

- A recent national survey of UK NHS patients, who had all received psychological treatment found that about 1 in 20 (5.2%) of people responding to the large survey [*n* = 14,587] reported experiencing lasting bad effects.[78]

- Scott Lilienfeld, a professor of psychology at Emory University, has done a number of studies, especially some for the APA, on treatments that possibly *"should be avoided … or only implemented only with caution"*.[79] However, this could also be (in effect) a sort of 'blacklist' – a worrying development in itself. These treatments include: critical incident stress debriefing; facilitated communication; recovered-memory techniques; boot camps for conduct disorder; attachment therapy; dissociative identity disorder-oriented psychotherapy; grief counselling for normal bereavement; and expressive-experiential psychotherapies.

- I have already written a fairly seminal article in this journal (Vol. 18, No. 3, November 2014: pp. 63-82) on *"The Possible Harmful 'Side-Effects' of Psychotherapy"*, in which I surveyed some of the literature on this topic.[80]

- There are also severe reservations – from a number of different studies[81] – about treatments such as: Eye Movement Desensitization and Reprocessing (EMDR); Thought Field Therapy (TFT); Adolescent Transition Programmes (APT); Encounter Groups; Grief counselling for normal bereavement; Energy psychotherapy; Angel therapy; Crystal healing; Past-life therapy; Re-birthing; 'Primal Scream' therapy; Erhard Seminars Training (EST); Neuro-Linguistic Programming (NLP); DARE programs; Re-parenting; Gender Re-assignment Therapy; etc.

In addition, we have to be very careful that we – the professional psychotherapists – like the medical profession, also **do no harm!** We are working with people who are often quite vulnerable – even fragile, psychically (which may not show up initially). There is quite a high drop-out rate in counselling and psychotherapy and these 'drop-outs' are often **not** followed up properly so as to find out why they stopped. This is vital information, and it is just not good enough to have a contractual clause that requires one session's notice. Maybe we need to be much more proactive in following up on a 'No Show', or a last-minute cancellation.

All this is especially true when working psychotherapeutically with children and young adults. In the UK, Child Psychotherapy is a specialist discipline, needing additional and specific training modules. Group work programmes with teenagers and young adults,

78. See **Crawford, 2016**.
79. See **Lilienfeld 2002, 2007**; see also **Lilienfeld *et al*., 2005**.
80. **Note**: This article is accessible as a PDF download from the IJP's website 'Catalogue' (left-hand side-bar) (for €3.00).
81. See **Thompson, 2005**.

often with severe behaviour problems, delinquency, and/or substance abuse, have an increased potential for interventions to produce negative outcomes. Not only does this raise a number of ethical issues, but the young person can then be damaged more than when they started therapy.[82]

Different 'Myths' About Counselling & Psychotherapy

There are a large number of myths about Counselling and Psychotherapy:

(1) 'The Myth of the Untroubled Therapist'[83];

(2) '20 Myths about Counselling & Psychotherapy'[84], which include:
- (a) Counselling / Psychotherapy never works
- (b) Counselling / Psychotherapy always works
- (c) Counselling / Psychotherapy is no good for Depression
- (d) Counselling /Psychotherapy is always good for Depression
- (e) Only Psychiatrists can do Counselling / Psychotherapy
- (f) Only Psychologists can do Counselling /Psychotherapy'; and so on;

(3) "Top Ten Myths about Counselling and Therapy"[85] which includes:
- (a) My therapist will know what I am thinking and/or can read my mind
- (b) I will have to lie on a sofa
- (c) I will be encouraged to blame my parents for everything
- (d) Therapy can go on for years and years
- (e) Therapy just isn't as effective as medication
- (f) My therapist is only interested because they are getting paid
- (g) Therapy is only for those who can't deal with their problems and are weak or 'crazy'
- (h) Therapy will quickly fix all my problems
- (i) Being with my therapist face-to-face is the only way of doing therapy
- (j) Talking to someone who doesn't know me won't help and they might judge me

(4) "5 Myths about Counselling – Debunked!"[86], which includes:
- (a) Counselling is only for people with serious mental health issues
- (b) It's easier to talk to friends and family about my problems
- (c) Counselling is nothing about endless talk about my childhood
- (d) Counselling takes ages: It's like writing a blank cheque
- (e) I tried it once and it didn't work, so counselling is not for me

(5) "The Myths about Counselling"[87], which include:
- (a) Only mad people need counselling
- (b) Counsellors just sit there and say nothing
- (c) Counselling takes forever

82. See **Rhule, 2005**.
83. See **Adams, 2013**.
84. See **Stephens, 2012**.
85. See **Jacobsen, 2012**.
86. See **Morrow, 2018**.
87. See **Martin, 2012**.

(d) Everyone will know you are seeing a counsellor
(e) Counselling will change the person you are; and so on.

All of these **myths** are just – quite literally - myths: that means they are not true. The only reality is that counselling or psychotherapy won't necessarily be what you expect; and it often works just to have another person listen to you talking about your life and issues.

Collaborative Practice (With-ness)

What is usually meant by "collaborative practice" is that the mental health practitioners work together with other professionals and with the service users and their families and support groups to "connect, collaborate and construct" with each other.[88] Each member of the 'team' then has a sense of participation, belonging and ownership, which combines to promote (much more) effective and sustainable outcomes. This is not the usual situation, where theory is put into practice and techniques employed in a way that the service user becomes a 'patient' – often a disempowered one, who is then 'treated' by 'professionals'. The collaborative practice model invites all of those involved into a shared engagement, a mutual inquiry, and a joint action – by the process of generative and transforming dialogue – making collaborative therapy and other such endeavors much more of a "with-ness" practice. Much of mental health practices involve thinking about the problem from the 'outside' and observing what is happening 'over there'. Collaborative practice is a form of engaged and responsive thinking, acting and talking with those involved. What can be gained from such 'understandings-from-within' is a subsidiary awareness of certain 'action-guided-feelings' that help to play a role in an ongoing process in which all are involved (in their different ways), all are responding differently, and there is then a sense or feeling of a collective and mutual process – a structure of tacit knowing – rather than just a clinical 'focus' on the person with mental health issues.[89]

There have been a number of attempts to work "collectively" with people in mental health situations – sometimes referred to as 'therapeutic communities' – however, these have largely been inspired by somewhat radical professionals (like R. D. Laing[90], E. Podvoll[91], L. Mosher[92], J. Berke[93], M. Bar-

88. See **Ness *et al.*, 2014**; **Shotter, 2012**; **Anderson, 2009**.
89. See **Polanyi, 1958, 2015**.
90. **R. D. Laing**: A British 'radical' psychiatrist who founded a therapeutic community, Kingsley Hall. (See: T. Itten & C. Young (Eds.), *R.D. Laing: 50 years after 'The Divided Self'*. Ross-on-Wye, UK: PCCS Books
91. **Edward Podvoll**: author of "The Seduction of Madness: Revolutionary insights into the world of psychosis and a compassionate approach to recovery at home" (1990) and "Recovering Sanity: A compassionate approach to understanding and treating psychosis" (2003) and medical director and founder of the Windhorse Community in Boulder, Colorado and the Windhorse model of treatment.
92. **Loren Mosher** was an American psychiatrist, who – when he was in London in the 1960s – became interested in alternative treatments for schizophrenia. He founded 'Soteria' (originally in San Jose, CA), as he believed that the violent and controlling atmosphere of psychiatric hospitals and the over-use of psychotropic drugs hindered recovery. Despite its success (it achieved superior results than the standard medical treatment with drugs), the original house closed in 1983 as further funding was denied because of the politics of psychiatry that were controlled by the pharmaceutical companies. Since then, other 'Soteria' community houses have been established in Switzerland, Sweden, Israel, Finland, Germany, Hungary and the USA. A 2008 systemic review analysed the success of the model.
93. **Joseph Berke** was an American psychotherapist who worked with R.D. Laing at Kingsley Hall in the 1960s. He then co-founded the Arbours Association in north London (on a similar 'community' psychiatric/mental

nett [94], etc.) and – unfortunately – their (often very successful) work has not lasted much beyond their lives. Yet, we can still allow them to inspire us to something 'better' or different from our usual practice.

So … How Can We – As Therapists – Improve?

We have discovered some ways already – as indicated above. There are also certain significant factors – and some of these can be remedied by keeping meticulous outcome data: e.g. 25% of the least helpful therapists produced effect sizes of 0.2 (Green *et al.*, 2014). If it is possible to imagine the possibilities of one's improved effectiveness – then the least 'helpful' therapists can still become much better.

There are certain significant factors – and some of these can be remedied by keeping meticulous outcome data: e.g., 25% of the least helpful therapists produced effect sizes of 0.2 [95]. If it is possible to imagine the possibilities of one's improved effectiveness – then the least helpful therapists can still become much better.

Getting both objective and supportive feedback on our actual practice (routine outcome monitoring) is usually considered as being absolutely necessary – as this leads to practice-based evidence. [96] Therefore, the use of outcome measures like CORE, OQ and/or PCOMS and engaging patients / clients with these "Clinical Support Tools" allows the client to 'see' their progress and helps eliminate any 'blindsidedness' on the part of the therapist: [97].

> To date, little attention has been given to understanding relevant mechanisms of formal feedback in psychological therapy. In order to understand and maximize the benefits of feedback, it is essential to explore potential mechanisms contributing to this effect. …
>
> Formal feedback may derive its benefits from its ability to help correct naturally occurring biases in therapists' assessment of their work. If these biases are seen as normal, but often avoidable if feedback is used, this may pave the way to greater acceptance of formal feedback by clinicians and enhanced outcomes for clients.

We can also cut down on the number of 'unnecessary' sessions – i.e. 6-8 sessions is often at the point of peak improvement. [98] It is also often not 'necessary' to see clients once a week. A wider interval (2-3 weeks) does not greatly reduce the effect of the therapy (unless

health model: www.arboursassociation.org). He is the author of several books including: I Haven't Had To Go Mad Here" (1979: Pelican) and "Beyond Madness: Psychosocial interventions in psychosis. (2001: Jessica Kingsley).

94. **Michael Barnett** was the founder of "People, Not Psychiatry" a radical anti-psychiatry movement in London in the late 1960s and early 1970s. He had been active in radical alternatives to psychiatry for some time, offering a programme based not on drugs, repression and a 'questionable' expertise, but on human caring, greater awareness of the body, deeper communication between persons, and a willingness to let the emotions flow. It was a challenging alternative, which came at a time when the viability of scientific, theoretical and chemical approaches to distress were being questioned at all levels of society. The alternative methods included some of the new direct methods of healing (making whole) such as Encounter, Gestalt, Bioenergetics, Psycho-fantasy – methods that do not do things to people but allow them to feel their way into change through experimentation, experience, flow and choice

95. See **Green *et al.*, 2014**.

96. See **Drapeau, 2012**.

97. See **Macdonald & Mellor-Clark, 2014**.

98. See **Lambert *et al.*, 2005**.

the client is in crisis); allows you to see more clients; and also allows the client a slightly longer time to put the 'lessons' from the last session into practice, discussing these and integrating these better, as well as extending the whole course of the therapy over a few months, rather than confining it to a few weeks.

And – ideally – one should try also to reduce drop-out rates (often around 25-35%) [99]; as well as not interpreting too much; and focusing on the seemingly 'inaccurate' or 'out-of-order'; and questioning (or exploring) the confusing or anxiety-provoking moments. Periods of silence are also often useful. [100] These are all little techniques that can help to improve one's personal professional psychotherapy practice.

However, there seems to be a considerable negative perspective within the profession towards such monitoring and thus towards improving one's practice: this was identified by Lambert (2007), though I believe that some of this 'resistance' is lessening as time passes:

> A few comments on the practicality of implementing a feedback system in routine care are in order. Generally, clinicians do not see the value of frequent assessments based on standardized scales, possibly because they are confident in their ability to accurately observe patient worsening and provide an appropriate response. Despite evidence suggesting that psychotherapists are not alert to treatment failure and strong evidence that clinical judgments are usually found to be inferior to actuarial methods across a wide variety of predictive tasks, therapist confidence in their own clinical judgment stands as a barrier to implementation of monitoring and feedback systems. In addition, clinicians are used to practicing in private and with considerable autonomy. Monitoring patient treatment response makes the effects of practice somewhat public and transparent. Such transparency inevitably raises evaluation anxiety and fears of losing control. Implementation requires the cooperation of therapists and takes time before it is apparent to clinicians that the feedback is helpful.

We, as a profession – rather like the old joke about the number of psychotherapists needed to change a light bulb – and as individuals, have to be prepared and willing to change.

The Four Magic Words: A Personal Professional Practical Note

On a more personal note, what I have found very effective are methods to increase the client's empowerment and their self-esteem. Most of the people referred to me (about 85%) have absolutely nothing wrong with them: they do not have a diagnosable 'condition'; they may (or may not) be taking anti-depressants. What they are mostly suffering from is an overload of stressful life events, and they mainly present with symptoms of (reactive) stress, anxiety, depression, grief and/or loss. Therefore, a compassionate and empathic approach is essential; a 'normalisation' of their situation helps put things into context and de-pathologizes their symptoms; some gentle explanations about the functioning of their autonomic nervous system often helps them to understand what they can do about re-bal-

99. See **Wierzbicki & Pekarik, 1993**.
100. See **Schultz, 2021**.

ancing it – exercise, relaxation, etc. [101]; and then I offer them the 'Four Magic Words'.

Perhaps it is necessary for me to disclose here that I have been practicing in a GP surgery on the outskirts of Edinburgh (for most of the last 20 years) just down the road from where the well-known author of the *Harry Potter* books lives. So, at this point I quite often say:

> *"We don't have any 'magic wands' I am afraid because we leave that to J.K. Rowling down the road. What I do have is 'Four Magic Words', and you can write them on the inside of your forehead, in letters of gold, so they are the first thing you think of – you can have them, if you want them."* They usually agree to this and so I then say, *"The Four Magic Words are: What – Works – For – Me? And, if whatever it is that doesn't work for you, then all you have to say is: 'That doesn't work for me'. Then, it is up to the other person to suggest something else."*

This is, of course, totally unscientific, unresearched, etc. – but it is simple, pragmatic, human and seemingly quite effective. Many people report very positively, often in the next session, that: *"It worked like magic! I said that to my ... (husband, sister, mother, etc.) ... and it worked! I felt so empowered."*

Such self-help practices that promote client empowerment are also reported to be very effective by other therapists and researchers. [102] One form of empowerment is to encourage the person to claim back their 'power of choice'. [103]

It is such a great pity that current UK mental health services are only really designed to respond (somewhat basically) to people with existing and identified mental health problems. However, what should probably be considered – instead – are: widely (nationally) applied structures and strategies that are designed to be more effective in preventing people actually developing mental health problems.

This needs to be done in a great number of different ways, as with: **(a)** better parental education in the pragmatics of child psychology (especially for new parents); **(b)** the teaching of 'emotional intelligence' and self-empowerment, especially in primary schools; **(c)** many more – properly funded – interventions from social work departments (and the like) helping with 'problem' families; **(d)** many more healthy 'youth' and 'after school' activities for secondary school pupils to give them a sense of identity; **(e)** better 'policing' and other social strategies to prevent children getting supplied with drugs, or joining gangs; **(f)** much more successful – and many more strongly enforced – (anti-)'stress@work' policies; **(g)** much better and more easily accessed 'couples' counselling' facilities; **(h)** better awareness from GPs (and other 'medical' professionals) that many of their patients' problems are not actually 'medical' or (possibly) 'psychological', but instead are probably 'social', or 'emotional', or 'existential'; **(i)** much more easily accessed (and less socially discriminative) resources for people with symptoms of anxiety and/or depression, usually from a quite serious accumulation of 'life-stress' events and issues; etc.

Here is the final word: Prevention is always better than treatment; and it is usually much

101. See **Young, 2008**.
102. See **McWhirter, 2011**; **Stosny, 2012**; **Pickett, 2014**.
103. See **Prochaska & Norcross, 2013**; **O'Morain, 2012**.

more effective; and it is often cheaper – in the long run. Working actively to prevent (or reduce) the next generation (and the next) getting 'mental health problems' is probably and actually 'What Works' best in psychotherapy and counselling.

Finally, this whole article (presentation) has – possibly – been superseded, or made redundant, by Clare Hill and John C. Norcross' very recently (July 2023) published book: *Psychotherapy Skills and Methods That Work.*[104]. I have sent off for my copy!

Author

COURTENAY YOUNG is a well-known and experienced UK psychotherapist and counsellor. He works as a Body, Humanistic and Transpersonal Psychotherapist. He has been living and working in and around the Edinburgh area and the Central Belt of Scotland for the last 20 years. Prior to that, he was the resident psychotherapist at the Findhorn Foundation, a spiritual community in north-east Scotland. He is the author of several books and many edited books, as well as having written many published articles. He is currently the Editor of the International Journal of Psychotherapy (www.ijp.org.uk) and a Trustee of the United Kingdom Council of Psychotherapy (UKCP). Most of his published articles are available as downloads from his personal website: www.courtenay-young.com

E-mail: courtenay@courtenay-young.com

Affiliations: UKCP[105] Registered Psychotherapist: 930083; NHS[106] Lothian Counsellor; EAP[107] ECP European Certificate of Psychotherapy; EAP Individual Member: 403157; EABP[108] Accredited Member: 271 & EABP Honorary Member; BPS[109] Member: 170847; Editor, International Journal of Psychotherapy; UKCP Trustee.

104. See **Hill & Norcross, 2023**.
105. **UKCP**: United Kingdom Council for Psychotherapy
106. **NHS**: UK National Health Service (Scotland)
107. **EAP**: European Association for Psychotherapy
108. **EABP**: European Association of Body Psychotherapy
109. **BPS**: British Psychological Society

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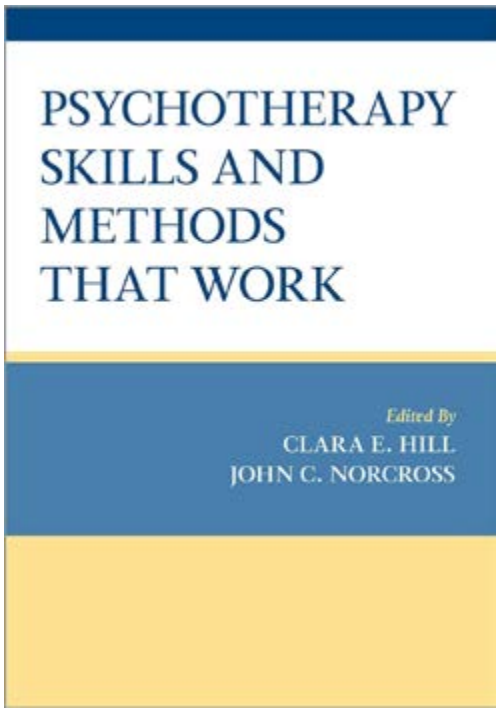
EXTENDED BOOK REVIEW



Psychotherapy Skills and Methods that Work

Edited by Clara E. Hill & John C. Norcross

Oxford University Press, 2023
Hardback: 718 pp.
ISBN: 9-780197-611-012
RRP: £92.00; $117.99-$135.72; €123.89

While we know that psychotherapy works, there is a hearty debate about what makes it work. In the past, rival arguments have maintained that psychotherapy proves effective because of the treatment approach, patient contributions, or the therapeutic relationship. *Psychotherapy Skills and Methods that Work* argues that clinical skills and methods also play a crucial role and that what therapists do has major consequences for improving practice.

[This book] is the result of a multiyear, interorganizational Task Force commissioned to identify, compile, and disseminate the research evidence and clinical practices on psychotherapist skills and methods used across [different] theoretical orientations. Edited by renowned scholars Clara E. Hill and John C. Norcross, this book provides original research reviews on the effectiveness of 27 specific psychotherapy skills and methods, including affirmation, self-disclosure, role-induction, between-session homework, empathic reflections, mindfulness and acceptance, emotional regulation, and cognitive restructuring. Each chapter on a therapy skill or method features clinical examples, diversity considerations, training implications, and bulleted therapeu-

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tic practices, while the final chapter summarizes the research evidence for the effectiveness of those skills/methods and emphasizes implications for clinical training and practice.

Forcefully demonstrating what therapists *do* to help clients change and live more effective lives, [this book] will serve as a go-to guide for psychotherapy practitioners of all persuasions and professions, as well as graduate students and psychotherapy researchers.

[From publisher's book cover]

Given this summary, the following material should be of interest to most readers of this journal. Of course, this book review (like the above) is just a summary and is no substitute for reading the original. The editors – and the Steering Committee – have collected contributions from 66 different authors in 23 chapters, which cover 27 specific types of method, and – in the Introduction to the book – emphasize that:

> *"Whereas there is considerable research evidence for the overall effectiveness of psychotherapy (Wampold & Imel, 2015) and for the association between a strong therapeutic relationship and positive outcome (Norcross & Lambert, 2019), there is, surprisingly, less empirical support for the effectiveness of specific therapist skills and methods. In this volume, we strive to redress that deficiency by focusing on skills and methods that can be used across theoretical perspectives.*
>
> *... [they] begin by weighing in on the debates about what accounts for change in psychotherapy, namely whether it is the treatment approach, the relationship characteristics of the client/patient, therapist responsiveness to client/patient needs, or client expectations that account for client outcomes. We then define and contextualise therapist skills and methods, especially in regard to other components of psychotherapy. Next, we take a deeper dive into how skills and methods are assessed, how outcomes (immediate in-sessions, intermediate, and distal) are assessed, how to link skills and methods with outcomes, and how to summarize the extant research on those skills and methods. Such research summaries – naturally and ideally – generate evidence-based therapeutic practices, which end all subsequent chapters in this volume. We conclude by outlining the purpose and process of the intergenerational Task Force that guides this book."* (pp. 1-2)

The editors [1] then focus on the principles of what accounts for change in psychotherapy, owning that there are a multiple of variables, which promote a huge debate. A pertinent question, as asked by Norcross & Lambert (2019, p. 1), *"Do treatments cure disorders, or do relationships heal people? Which is the most accurate version for practicing, researchers, and teaching psychotherapy?"* (p. 2)

The next question is extremely pertinent: Do we consider all this: **(a)** from the perspective of the 'Medical Model' (*It's the Treatment Approach that Matters*); or **(b)** from the perspective of the 'Relationship Model' (*It's the Therapy Relationship that Matters*); or **(c)** the 'Client/Patient Factors' (*It's the Client/Patient that Matters*); or **(d)** the 'Therapist Effects' (*It's the Person of the Therapist that Matters*), or **(e)** is it Personalizing (*It's Responsiveness that Matters*), or **(f)** is the Therapist Skills and Methods (*It's What the Therapist Does that Matters*)?

In conceptualising the overt behaviours of psychotherapists, they state that these occur at **four levels of abstraction**: **(1)** At the

1. Clara E. Hill, John C. Norcross & the Steering Committee

macro level are 'brand names': i.e., *treatment approaches* (such as psychodynamic, systemic, cognitive-behavioural, humanistic, etc.) which are large and multi-faceted, involving a multitude of skills and methods, usually applied by therapists in idiosyncratic ways, albeit trained in those methods. **(2)** At a second level of abstraction, between global theories and specific methods, are – they tell us – *change principles or processes*, which include raising awareness, counter-conditioning principles that cut across treatment packages (or 'techniques'), that might include raising the client's awareness of their problems or defences and teaching them skills that counter or inhibit their problems. **(3)** The third level of abstraction are *psychotherapeutic methods* or *techniques*, such as chair work, paradoxical intervention, dream work, teaching mindfulness, or cognitive restructuring. **(4)** At the micro level of abstraction, they say, are relatively discrete *therapist or helping skills*, such as reflections of feelings, interpretations, questions (used to gather facts, explore thoughts and feelings, probe for insight or action ideas), metaphors, and immediacy (talking in the here-and-now about the therapy session or relationship), or different, readily-taught skills (*verbal response modes*): these are sometimes packaged into method and can be delivered by the many, existing mental health training programs.

> *Hence, in a complementary and hierarchical fashion, skills are nested within methods, which are in turn embedded within change principles or processes, which are embedded within treatment approaches or packages.*
>
> *... A clarification of import: Therapist methods are frequently and erroneously conflated within entire treatment packages or psychotherapy systems. [this error is characterized] as the exclusivity myth in psychotherapy – that certain processes or methods are the exclusive properties of particular therapy approaches (Norcross, 1995). ... A second clarification: In the preceding section, we have alluded only to occurrence of therapist's behaviors at the four levels but have not considered competence. Clearly, it is not just whether a therapy behavior occurs but also how effectively it was implemented according to different perspectives (therapist, client, significant other, external judge).* (p. 8)

They have then assessed the various skills and methods using a variety of approaches in research and training: **(a)** overall estimates by trained judges; **(b)** quantitative ratings by therapists and clients; **(c)** qualitative assessments of skills and methods; and **(d)** open-ended interviews of participants about the skills/methods. Finally, having reviewed and summarized the research, training implications and therapeutic practices are mentioned for each approach. The Interorganizational Task Force is then introduced, and its *modus operandi* is mentioned, which completes the Introductory chapter.

Affirmation / Validation, Self-disclosure, Immediacy and Rupture Repairs

The first set of 'methods' or 'skillsets' described in detail in Chapter 2 are those of: "Affirmation / Validation, Self-disclosure, Immediacy and Rupture Repairs" (pp. 28-52). The authors of this chapter[2] acknowledge the deep and abiding synergy between psychotherapy methods and the therapeutic relationship. The define 'Affirmation/Validation' using a quote from Carl Rogers, focusing on

2. Barry A. Farber, Clara E. Hill, Sarah Knox, Catherine F. Eubanks, J. Christopher Muran & John C. Norcross.

the therapist's positive regard and warmth, crucially counterbalancing most peoples' feeling of lack of worth, imposed by parents and society. Implicit in this is his disapproval about the arrogance of therapists (at that time) presuming a hierarchy distinction between themselves and their patients or clients. Not only did he believe that the client was the expert in their condition, but he also offered unconditional positive regard, believing that this would inevitably help them to grow psychologically to fulfil their potential. Each one of these methods is followed by a 'Research Review", "Training Implications" and "Therapeutic Practices". Therapist self-disclosure and Immediacy, being slightly more controversial techniques, are defined both separately and together, and then there are sections on research review, training implications and therapeutic practices. Finally, in this chapter, 'rupture repairs' are defined and discussed, the research is reviewed and training and practice implications are mentioned. This and all the following chapters have extensive references.

Questions

The next effective method or technique put forward are "Questions", (Chapter 3, pp. 53-73) with first a rationale and then a definition given by the author [3]. I remember one of my trainers discussing the 'obscenity' of questions, (as if the therapist is interrogating the client) though they may be appropriate in the earlier (intake) stages and open questions can, of course, be useful towards a deeper understanding of the client. Types of questions in therapy, besides the purely interrogative, include: rhetorical, Socratic, hypothetical (what if), challenging, expansive, and the 'miracle' question. It is quite difficult to measure therapists' use of questions and three groups of measures of immediate and intermediate outcome are used: **(a)** *observer-coded* (using transcripts or video tapes; **(b)** *client-per-post*; and **(c)** *client & therapist post-session reviews*. The link between question use and outcomes may be important, but it may be more useful to study the micro-processes to understand the immediate impact of questions. Some clinical examples are given: **1)** Considering diversity; **2)** Considering timing; and **3)** Considering focus. Although there is not much. Empirical research on the effectiveness of questions, one study 'set the bar' for process-outcome research: Hill *et al.*, 1988, which is described (p. 59) and a research review located about 10 empirical studies that were tabulated (pp. 62-53) and the positive and negative impacts were described, including the possibility of harm, so that both the client's and therapists emotional content and reactivity need to be taken into consideration, especially in cases of diversity and social identity. As before, Training and Practice Implications are indicated.

Socratic Questioning & Guided Discovery

The third recommended approach that works is "Socratic Questioning & Guided Discovery" (pp. 74-98) where the authors [4] describe these methods and their clinical use in some detail. Their definition, *"open-ended exploratory questions, often integrated with guided discovery"* whereby the therapist directs the conversation towards the uncovering of the client's core beliefs, especially those related to adaptive functioning. Whilst this technique

3. Elizabeth Nutt Williams
4 James C. Overholser & Eleanor Beale

can be useful within many forms of psychotherapy, a modest level of cognitive complexity from the client and considerable patience from the therapist is required. It avoids the therapist assuming the role of expert or teacher and shuns the semi-educational format: it is more a voyage of discovery! The less well-known technique of Guided Discovery relies on a process of shaping:

> *"... whereby the discussion gently flows closer toward meaningful issues and useful strategies. Instead of trying to solve a specific problem for the client, the therapist helps clients learn to solve problems by cultivating general attitudes that underlie emotional stability and effective coping (Overholser, 2013)."* (p. 79)

Guided Discovery includes core beliefs, such as: 'Planful Strategy', 'Inductive Reasoning', 'Disavowal of Knowledge' and 'Hypothesis Testing'. As with all the other chapters dealing with a variety of methods that work, the initial descriptions are followed by methods of 'Assessment', 'Clinical Examples', a 'Research Review' (in this case, very detailed, with possible negative effects identified (after all, this type of questioning got Socrates into trouble), 'Diversity Considerations', 'Research Limitations', 'Training Implications' and 'Therapeutic Applications'.

Empathic Reflection

Chapter 5 (pp. 99-137) addresses a method that is relatively familiar to many psychotherapists, "**Empathic Reflection**", where the authors[5] note that the primary role is to "reflect back" or share the therapist's understanding of the client's communication and underlying experiences. This *response mode* is a form of qualitative feedback, a skill, which forms one of the primary tools of several different psychotherapy approaches (especially, person-centred, experiential, humanistic, counselling, etc.). The description of this technique is extensive, listing nine types of empathic reflection responses (Table 5.1, p. 103): Empathic repetition, Empathic reflection, Evocative reflection, Empathic affirmation, Exploratory reflection, Process reflection, Empathic formulation, Empathic conjecture and Empathic refocusing. As to be expected, this description is followed by sections such as: Clinical Description and Indications, Assessment, Clinical Examples, Landmark Studies, with an extensive Research Review, Possible Negative Effects and Harms, Training Implications, Therapeutic Practices, and several pages of references.

Metaphors

The next chapter (Chapter 6, pp. 138-164) deals with the use of "Metaphors". The authors[6] first describe this mode of communication, often used in everyday life. Given that psychotherapy is a "talking cure", it is not surprising that this is often used as a facilitator of client change.

> *"Much has been made of the distinction between what are called conventional, frozen, or dead metaphors and what are called non-conventional, novel or living metaphors. ... It is these that have often been proposed as most important for the tasks of therapy. ... metaphors have been proposed as a way of structuring therapy, itself, and as a form of therapy, as in externalising metaphors therapy."*

5. Robert Elliot, Arthur C. Bohart, Dale G. Larson, Peter Muntigl & Olga Smoliak
6. Linda M. McMullen & Dennis Tay

The chapter continues with 'Clinical Descriptions and Indications', which illustrates some of the therapeutic usage, followed by a section on 'Assessment' (of Outcomes: Immediate, Within-Session and Delayed, Immediate Post-Session; and Distal, End-of-Treatment), and then a fairly long 'Clinical Examples'. The section on 'Landmark Studies and Previous Reviews' is followed by a section on 'Research Review' with an extensive Table 6.1 (pp. 150-154) of 14 research studies; followed by the usual sections on 'Possible Negative Effects and Harm', 'Diversity Considerations', 'Limitations of the Research', 'Training Implications' and 'Therapeutic Practices'.

Interpretations

In Chapter 7, (pp. 165-198) starts off by claiming that *"Interpretations are a fundamental component of most psychodynamic treatments and a common feature of other forms of psychotherapy."* The aim of interpretations is to raise the level of the client's insight:

> *"Insight is commonly defined as awareness of one's recurring emotional, cognitive, behavioral, and interpersonal patterns, manifested as a conscious shift in meaning involving the creation of new connections that can be seen as enabling more adaptive coping. ... The process of raising awareness and understanding of recurring maladaptive is transtheoretical, although manifesting differently across theoretical orientations."*

In the section on 'Definitions', the authors [7] describe a broader, transtheoretical definition of interpretation:

> *"a statement that goes beyond what the patient has overtly stated or recognized and gives a new meaning, reason or explanation for behaviors, thoughts and feelings so that the patient can see problems in a new way."*

Some interpretations focus on *intrapersonal*, others on *interpersonal* conflicts or maladaptive recurring patterns. In the section on 'Clinical Description and Indications', the authors describe how the therapist can carefully explore the patient's reaction: they also suggest that an interpretation should come in the middle of the session, as it often takes some time to work through potential meanings and a sufficiently strong alliance may not have been informed, and providing it too early may prevent establishing a strong enough alliance to serve as a supportive environment for the interpretation. There is also an ongoing debate regarding the characteristics of the patients who may benefit from interpretations.

In the section on 'Assessment', measurement of the occurrence of interpretations can be divided into those estimating the extent to which interpretations were a characteristic of the sessions, or those focusing on the frequency of interpretations used in a session. Other measures rely on whether interpretations have occurred or not; or on whether the measures assess the accuracy and quality of the interpretations. Three 'Clinical Examples' are given, where the first interpretation refers to an interpersonal conflict outside the therapy room; the second relates an interpersonal conflict; and the third is an interpretation of transference. The section on 'Landmark Studies and Previous Reviews' is followed by a 'Research Review', with a table (7.1, pp. 173-183) of 12 research studies, which are followed by sections on 'Associations between Interpretation and Immediate / Intermediate / Distal Outcomes', followed by 'Possible Negative Effects and Harm', 'Diversity Considerations', 'Limitations on the Research', 'Training Implications' and finally 'Therapeutic Practices'.

7. Sigal Zilcha-Mano, Hadar Fisher, Tihar Dolev-Amit, John R. Keefe & Jacques P. Barber

Paradoxical Interventions

The next method described 'that works' in Chapter 8 is "Paradoxical Interventions" (pp. 199-223), which are intended to help clients become more flexible, or at least open to thinking about their problems from a new perspective. The authors [8] state:

> *"Among the potential benefits from PIs are that they often produce rapid behavioural change on the second-order level (i.e., change on a systemic or structural level of functioning)."* (p. 199)

However, they can also be deceptive or manipulative, but, when used appropriately, can be demonstrably effective: PIs should be nondirectional and encourage change by giving clients a choice between options:

> *"... an explicit PI consists of seemingly self-contradictory and sometimes even absurd therapeutic perspectives about a client's circumstances. The use of opposite meanings, or defying a client's expectations about what a therapist should say, may also be humorous. However, the element of truth that is present makes PIs real and unavoidable, rather than an elaborate joke that can be easily dismissed."* (p. 200)

However, the authors also state that – in order to understand the therapeutic use of PIs, it is important to consider the concept of *dialectics*, which are explained. This section is followed by 'Early Paradoxical Techniques' and then 'Recent Therapeutic Approaches to Paradoxes'. Psychotherapists' specific strategies for achieving second-order change are: *"neutralisers, tranquilizers, energizers, and challengers"* (p. 203) and these are described next. These are followed by the usual sections on 'Assessment', 'Clinical Examples', Landmark Studies and Previous Reviews', an extensive 'Research Review', and then, 'Diversity Considerations', 'Limitations of the Research', 'Training Implications', and 'Therapeutic Practices'.

Advice, Suggestions, Recommendations

In therapeutic exchanges, we often use "**Advice, Suggestions, Recommendations**" (ASR). The authors [9] of this chapter, Chapter 9 (pp. 224-246) state that these are all ways in which psychotherapists gently encourage their clients to do something in the hope of facilitating change. Definitions of ASR include: *direct guidance – "making suggestions, giving directives, or providing advice for what helpers think clients might do outside of helping sessions"*. Sometimes, these are 'recommendations', 'directives', 'homework', or 'advice'. Direct Guidance (DG) should, of course, be used cautiously and range from implicit and indirect to very direct.

> *Those adhering to cognitive behavioral therapy (CBT) frequently offer ASR and homework assignments, for they view the therapist's as taking the lead in guiding clients to address specific concerns in session and serving as a guide or Socratic educator. Indeed, some have suggested that failure to use ASR could harm the therapeutic relationship if clients perceive the clinician as uncaring or unconcerned.* (pp. 225-226)

In the next section on 'Clinical Description and Indications', the authors write that:

> *Some theorists suggest that ASR, and DG more broadly, are optimally used to help cli-*

8. Paul R. Peluso & Robert Freund
9. Clara E. Hill, Sarah Knox & Changming Duan.

> *ents make behavior changes after the therapeutic relationship has been established and there has been sufficient exploration and insight work. The rationale is that psychotherapists need to help clients explore their concerns, experience the underlying emotions, and understand what is going on within themselves before helping clients begin to alter their behavior or environment.*
>
> *In addition to these client factors, therapist beliefs about the change process undoubtedly dictate their degree of directiveness: If psychotherapists believe that they are the experts whose role is to diagnose and solve problems, then they are more likely to prescribe actions. In contrast, if psychotherapists believe that they function more like facilitators and fellow journeyers with clients being the active agents of change, they are more likely to eschew giving explicit advice.* (p. 226)

This section is followed by the usual sections on 'Assessment' , 'Clinical Examples', 'Landmark Studies and Previous Reviews'. In the section on 'Research Review', there is a Table (9.1, pp. 232-235) that list 'Studies of Immediate and Intermediate Outcomes'. The following sections are, as usual, on 'Possible Negative Effects and Harm', 'Diversity Considerations', 'Limitations of the Research', Training Implications' and 'Therapist Practices'.

Integrating Between-Session Homework

In Chapter 10 (pp. 247-280), the authors [10] describe that this 'method that works' (BSH) includes:

> *"... extra-therapy assignments, extra-treatment practice assignments, in vivo behavioral practice assignments, and home practice activities, to name a few.*
>
> *A common rationale for engaging clients in BSH is to foster learning in some form, but there is diversity in what constitutes between-session activities across treatment approaches. To illustrate, BSH may compromise such diverse methods as bibliotherapy, promoting emotional awareness, reflection, relaxation exercises, self-monitoring to understand the connection between daily activities and mood, recording one's automatic thought and developing alternative responses, exposure to feared stimuli (in vivo, imaginal, or interoceptive), as well as scheduling and engaging in activities to promote a sense of accomplishment or pleasure, just to name a few.*

There are differing opinions is to what extent BSH should be initiated, suggested, or even prescribed by the therapist; self-initiated by the client; or collaboratively negotiated between therapist and client. Again, in most cognitive and behavioural therapies, the process of designing, planning, and reviewing BSH is explicitly on the agenda for each session, although negotiated between therapist and client and undertaken with collaborative empiricism. BSH is not emphasized in traditional psychoanalysis or psychoanalytic psychotherapy, but it has been advocated for and reported being used by psychodynamic therapists. Apparently, humanistic and experiential psychotherapists sometimes include BSH, tailored to fit the client and circumstances, but overt planning of BSH is usually seen as incompatible with the basic tenets of classical humanistic theory, but client-initiated BSH is apparently welcomed, typically in the forms of suggestions, rather than being required or expected.

10. Truls Ryum, Mia Benton & Nicholas Kazantzis

There are following sections on: 'Clinical Description and Indications', Assessment', and in the section on 'Clinical Examples', there is a 'Box 10.1: Examples of Action-Oriented Between-Session Homework in Psychotherapy' (p. 254), followed by 'Landmark Studies and Previous Reviews', which includes 'Box 10.2: Examples of Insight-Oriented Between Session Homework in Psychotherapy', followed by 'Landmark Studies' and 'Previous Meta-Analyses and Reviews'.

The section on 'Research Review' contains a Table 10.1 listing 24 studies (pp. 260-263), some of which are Quantitative Studies and Immediate Outcomes. Then, there is a section on 'Possible Negative Effects and Harm', followed by 'Diversity Considerations', 'Limitations of the Research', 'Training Implications', and 'Therapeutic Practices'.

Silence

Chapter 11 is a long chapter, entitled "Silence" (pp. 280-326). The authors [11] state the use of silence:

> *"... has long been seen as compelling but as enigmatic. Because silences are, by definition, a lapse in verbal communication between speakers, they may be experienced as impenetrable and so pose particular problems for psychotherapists."* (p. 281)

Instead of being an absence or a lack, a nothingness, silence is a deeply interactional process in psychotherapy. The section on 'Clinical Descriptions and Indicators' describe how:

> *"Ideally, silent moments in psychotherapy occur when clients are deeply tuned in with themselves and novel experiences and insights unfold. They can be moments when therapists are guiding and supporting, communing with clients, and gaining insights into clients' internal worlds and needs. Their structuring may support clients' ability to become comfortable with self-examination, to e4nhance exploration, and to embrace a sense of agency and self-direction.*
>
> *At the same time, these moments can be associated with anxiety, negative transference, and resistance for clients. Clients may feel paralyzed and uncertain how to respond when threatening issues arise. They may not feel comfortable telling the therapist when they do not understand or ardently disagree with a perspective that has been shared. And these more challenging silences can leave the therapist baffled on how best to respond."* (p. 283)

This is followed by a section on 'Assessment', and then 'Clinical Examples' (with a hypothetical transcript), 'Landmark Studies and Previous Reviews'. The 'Research Review' contains a selection flow diagram (Fig. 11.1; p. 289). The various tables (11.1 – 11.10: pp. 292-308) follow containing numerous studies. These are categorised and discussed in the following pages. Sections on 'Possible Negative Effects and Harm', 'Limitations of the Research', 'Diversity Considerations', 'Training Implications' and 'Therapeutic Practices'.

Facilitating Dyadic Synchrony

In Chapter 12 (pp. 327-366) on "Facilitating Dyadic Synchrony", the authors [12] describe how:

> *"Clients communicate their internal states not only verbally but also through facial ex-*

11. Heidi M. Levitt & Zenobia Morrill
12. Dana Atzil-Slonim, Christina S. Soma, Xinyao Zhang, Adar Paz & Zac E. Imel

> *pressions, vocal tones, and body movements. Therapists' ability to identify and express nonverbal communication, their sensitivity to slight changes in clients' behavior and emotions, their awareness of their own bodily sensations and expressions, and their ability to regulate affect together with clients are all crucial clinical skills that underlie many verbal therapeutic methods. The core of these abilities is the facilitation of* ***dyadic synchrony****, or enabling the coordination of physiological and behavioral signals between client and therapist."* (p. 327)

At this point, I am pleased to recommend a colleague's book on this particular topic: *Verbal and Nonverbal Communication in Psychotherapy*, by Gill Westland (W.W. Norton & Co.: 2012). This synchrony plays to play a central role in building rapport between individuals, in co-regulating emotional states, and in improving social learning and is thought to be an ancient survival mechanism that elicits coordinated actions and assists infants, who are dependent on communicating non-verbally with their care-givers, who help regulate their physiology and behavior and on whom they are dependent for their survival. Individuals gradually develop more productive self-regulation abilities and better impersonal skills, which – in turn – lead to enhanced well-being.

> *"Many psychotherapeutic theories highlight the importance of synchrony between clients and therapists. According to these theories, psychotherapy seeks to provide seeks to provide clients, whose development lacked early synchrony with an emotionally attuned other, a corrective emotional experience that replicates more optimal development. Therapists' ability to attune their behavior and physiology to clients' nonverbal communication and accelerate or decelerate their own arousal in response to clients' signals may allow clients to expand their emotion regulation capacity, leading to better therapeutic outcomes."* (p. 328)

There are many synonyms for this type of dyadic synchrony (congruence, convergence, mimicry, coordination, matching, reciprocity, etc.), but what is meant is the therapists' ability to become co-ordinated with the client's behavioral and physiological dynamics and their clients' nonverbal cues: both rhythmic, temporal qualities that change over time, and non-random. Finally, given that it is a complex phenomenon, a central aspect is the co-regulation of emotional processes – or the ways in which the presence of one member promotes affective homeostasis in the other.

> *"There are several steps a therapist can take to make synchrony beneficial for the client. A skilled therapist is aware of small shifts in the client's affective and bodily states, tracks the intensity and direction of the client's affective charge, and helps the client regulate more intense emotions. Therapist's ability to be attuned to the nonverbal moment-to-moment rhythmic structures of clients' internal states and to modify their own behaviour to synchronize with that structure is a crucial clinical skill. ...*
>
> *A skilled therapist can flexibly move in and out of synchrony, and theories suggest that this pattern is more adequate than either too few levels of synchrony. ...*
>
> *Therapists can be attuned to the clients' nonverbal behavior and allow themselves to be influenced by it. At the same time, it is important for therapists to regulate their own affective and bodily states, which can change in response to the client's experiences, to help the client regulate their emotions."* (p. 330)

The following sections on: 'Assessment' including both 'Behavioral Measures', 'Phys-

iological Measures', and 'Verbal Measures'; some 'Clinical Examples'; 'Landmark Studies and Previous Reviews'; and a 'Research Review' with Table 12.1 with 8 studies, Table 12.2 also with 8 studies, Table 12.3 with 14 studies, and Table 12.4 with 15 studies. Then there are sections of 'Possible Negative Effects and Harm', 'Diversity Considerations', 'Limitations of Research', 'Training Implications' and 'Therapeutic Practices'.

Role Induction

In Chapter 13 (pp. 367-398), the concept of "Role Induction" – particularly valid at the beginning of the psychotherapeutic relationship – is defined by the authors [13] as:

> *"... the process of providing patients with education designed to prepare them for psychotherapy and help them build accurate expectations regarding the roles and behaviors that may occur within that relationship. Although the exact information that is presented during role induction may vary depending on the individual client, the setting, or the specific treatment that will be used, the process of doing role induction is a pan-theoretical method that prepares patients for psychotherapy, regardless of theoretical orientation."* (p. 367)

This can be distinguished from other early treatment methods, including those that accommodate patient preferences and build patient hope, such as: shared decision-making, collaboration, and discovering patients' personal beliefs, experiences, and information that would be helpful – to the therapists – for their treatment, focussed on building accurate and realistic expectations for treatment. Personally, I think that this 'skill' is a required skill and even a necessary competency for all psychotherapists. Whilst some patients believe:

> *"... that it will only take two or three sessions of psychotherapy to solve their presenting concerns. This is an overly optimistic or hopeful outcome expectation. Role induction can help patients build more realistic beliefs about duration."* (p. 368)

What is probably necessary here is a much better differentiation between psychotherapy and counselling and a proper continuous 'stepped-care' model, where people can get help at different levels of intervention, and then – if one of these is not sufficient – they can get more specialised help, without falling between the cracks, or off the radar.

There then follows sections on 'Clinical Descriptions and Indications', 'Assessment', Clinical Examples' (including a couple of Case Examples), 'Landmark Studies and Previous Reviews', a 'Research Review', which includes 'Inclusion Criteria', 'Search Strategy', 'Study Coding', and 'Methodological Decisions'. Table 13.1 includes 17 studies. Other sections include: 'Client Experiences of Role Induction', 'Immediate In-Session Impacts', 'Effect on Dropout', '... on Mid-Treatment Outcomes', '... on Post-Treatment Outcomes', 'Patient Moderators of the ...' (with 2 more tables), 'Psychology Moderators of the ...', and 'Condition Moderators ... of the Role Induction Effects', with a 'Summary of the Results', and then the usual 'Possible Negative Effects and Harm', 'Diversity Considerations', 'Limitations of the Research', 'Training Implications' and 'Therapeutic Practices'.

13. Joshua K. Swift, Elizabeth A. Penix & Ailun Li

Collaborative Assessment Methods

Chapter 14 (pp. 399-428) describes "Collaborative Assessment Methods" (CAMs), in which the authors [14] outline a method of working with clients during all phases and aspects of psychological assessment and testing. There are various types of assessment methods, used at various times throughout the treatment. These methods are particularly relevant for relatively short-term treatments.

> *"CAMs are rooted in humanistic and phenomenological psychology principles. Key elements of the method are to collaborate with the clients and to emphasize the understanding of how their psychological features interplay with their "lively flux" of experiences, with the goal of "not just to describe or classify the person's present state but to identify viable options to problematic comportment".* (p. 400)

CAMs are also consistent with a social constructionist approach that acknowledges the clients as experts in their own lives. Systemic thinking is also integral to CAMs. The main methods are: **(a)** involving clients in setting their goals for the assessment; **(b)** engaging clients in discussing their experiences; and **(c)** jointly understanding how results relate to their goals. Providing clients with comprehensive feedback can be seen as an example of narrative therapy.

The rest of this chapter deals with: "Clinical Description and Indications"; "Assessment"; some "Clinical Examples"; "Landmark Studies and Previous Reviews"; the "Research Review" (which includes Table 14.2 with 10 studies, Table 14.2 with 7 studies, Table 14.3, Table 14.4, and Table 14.5, with 6 studies); "Possible Negative Effects and Harm"; "Diversity Considerations"; "Limitations of the Research"; "Training Implications" and "Therapeutic Practices".

Routine Outcome Monitoring

This chapter, Chapter 15 (pp. 429-471) deals with "Routine Outcome Monitoring" (ROM) one of the most successful "methods" (of monitoring) that works in psychotherapy, and it is used widely – it is actually 'required' in the National Health Service in the UK. Routine monitoring is an important element of patient-centred care and, when used fully and consistently, helps to enable effective and high-quality treatment. Psychotherapists have often been found to be over-confident in evaluating their own effectiveness, however ROM is important – if not necessary – to be able to enhance the validity of in-session therapeutic interactions, even though it calls for a measurement-based approach, informed by data and using feed-back. The authors [15] define the various different descriptions of ROM as containing common features grouped into 3 distinct phases: **(a)** collecting patient data on a regular basis; **(b)** feeding back these data to the therapist and, on many occasions, also to the patient / client; and **(c)** when appropriate, adapting the process or focus of the therapy in the light of the feedback; all of which have been labelled as a "trans-theoretical model of measurement-based care, named Collect, Share, Act". A more inclusive definition of ROM describes it as "the implementation of standardized measures, usually on a session-to-session basis, to guide clinical decision-making, monitor treatment progress,

14. Filippo Aschieri, Arnold A.P. van Emmerik, Carlijn J.M. Wibbelink & Jan H. Kamphuis
15. Michael Barkham, Kim de Jong, Jaime Delgadillo & Wolfgang Lutz

and indicate when treatment-adjustment is needed." It is also described as "relatively straightforward evidence-based practice … that the clinician can add to any type of psychotherapy … without requiring changes in that psychotherapy". (p. 430)

The American Psychological Association (APA) has long recommended the use of ROM and feedback methodology in routine care, and it is recommended that, "Psychologists aim to routinely assess treatment process and outcomes and integrate that information in ongoing collaboration with their patients.]". The Roadmap for Mental Health Research in Europe has adopted a similar position and the regulatory bodies in some European countries have made measuring treatment outcomes a requirement. (p. 431)

As mentioned, the third phase – of adapting the process in the light of feedback – is perhaps the most significant. The therapist's knowledge of the clinical and research evidence relating to the patient's response to treatment can include: "… contextual (e.g., lack of social support in the patient's life), process (e.g., a difficult therapeutic relationship with the patient), and patient factors (e.g., the presence of co-morbid conditions)."

The chapter then includes sections on: "Assessment"; "Clinical Examples"; "Landmark Studies and Previous Reviews"; a large "Research Review" that mentions about 50 different studies and has a number of sub-sections; followed by the usual "Possible Negative Effects and Harm"; "Diversity Considerations"; "Limitations of the Research"; "Training Implications"; and "Therapeutic Practices", with nearly nine pages of references.

Strength-Based Methods

In the next chapter, Chapter 16 "Strength-Based Methods" (pp. 472-501), the authors [16] look at how the methods that reduce symptomatology often comes at the expense of enhancing patients' strengths, adaptive skills and resilience: clients may be struggling in one domain (e.g., social withdrawal) while functioning well in other domains (e.g., professional career). They give definitions of strength and resilience-based methods, its measures, existing meta-analytic evidence and clinical examples.

Strength-based methods (SBM) represents efforts to respond sensitively to the patient's strengths in psychotherapy without neglecting their sufferings. They are based on the premise that working with patients' strengths is key to psychotherapeutic change, as attention to their strengths acknowledges the richness and diversity of their lives. "The unpleasant, unsatisfying, and disturbing parts as well as the pleasant, satisfying, functional parts of behavior are integrated into a fuller picture of mental health." (p. 472)

Strength-based psychotherapy refers to multiple treatment approaches, including positive psychotherapy, strength-based and/or resilience-focussed cognitive-behavioral therapy, and psychotherapy integration. There are probably no major psychotherapy orientations in which SBM are not emphasized. In CBT, some methods are designed to promote and maintain pleasant states and to elaborate on adequate therapy goals, and there are also versions of psychodynamic therapy that focus on strengths, insight, meaning-making, and thriving in relationships. SBM are also identified as a basic identity factor in counselling

16. Christopher Flückiger, Thomas Munder, A.C. Del Re & Nili Solomonov

psychology and humanistic psychology. In a broader context, related concepts for the integration of capitalization methods into mental health services include: empowerment, recovery, salutogenesis, and meaning of life. The emphasis on strengths is also synchronous with the emergence of patient-centered care.

As with other chapters, there are sections on: "Clinical Descriptions and Indications", "Assessment", "Clinical Examples", "Landmark Studies and Previous Reviews", "Previous Meta-Analyses", a "Research Review" that includes 'Inclusion Criteria' and details of 17 studies, as well as "Diversity Considerations", "limitations of the Research", "Training Implications" and "Therapeutic Practices".

Enhancing Emotion Regulation

Chapter 17, "Enhancing Emotion Regulation" (pp. 502-546) is another important psychotherapeutic method that "works". The authors [17] describe this one of the common core mechanisms of psychopathology and is an emerging trans-diagnostic focus of psychotherapy for a wide range of behaviours. Methods of enhancing patient emotional regulation across a variety of treatment packages include: **(a)** undoing avoidance of emotional emotions; **(b)** enhancing emotional awareness; **(c)** allowing the full experience of feared or avoided emotions; **(d)** learning effective cognitive reappraisal; and **(e)** learning behavioral and action strategies to modulate unpleasant emotions. Two types of psychotherapists tend to use this approach: the first consists of structured psycho-education and ER skills training rooted in the cognitive-behavioral tradition; the second group consists of affect-focused, experiential treatments, like emotion-focused therapy; accelerate experiential dynamic psychotherapy; and short-term dynamic psychotherapy. The given definition of Emotional Regulation (ER) is that:

> *"... which keeps the individual within a window of tolerance in which optimal emotional functioning is possible. ER is considered to be intrinsic to mental health and adaptive psychological functioning.*
>
> *ER encompasses a combination of the down-regulation of negative emotions and up-regulating positive emotions. It involves both internal and external actions to initiate, increase, maintain, decrease, or transform both positive and negative emotions in response to changing demands of emotion-evoking situations."* (p. 503)

There is no single therapeutic method directly associated with enhancing patient ER. So, it can be described as group of therapeutic methods and responses designed to build and strengthen patients' ER capacities, encompassing a variety means: providing relational and dyadic responses; facilitating emotional processing and transformation; and teaching skills for tolerating distressing emotions.

The chapter also includes sections on: "Clinical Description and Indications"; "Clinical Examples"; "Landmark Studies and Previous Reviews"; the "Research Review", which includes a 'Search Strategy and Inclusion Criteria' and Table 17.1, which lists 10 reviews; 17.2, which list 25 reviews; and 17.3 which lists the Effect Sizes. There are also sections on "Possible Negative Effects and Harm"; Diversity Considerations"; "Limitations of the Research"; "Training Implications" and "Therapeutic Practices".

17. Shigeru Iwakabe, Kaori Makamura & Nathan C. Thorma

Chairwork

Chapter 18 (pp. 547-576) describes "Chairwork" – a therapeutic method that has been used for almost 100 years in which the client engages in imaginal dialogues with various people in their lives. These are unscripted dialogues with varying degrees of structure: **(a)** between the client and an aspect of themselves, or **(b)** between the client and another person with whom a relational conflict exists. Its main objective is to explore underlying feelings and their associated meanings as a way of resolving personal difficulties. It is often used in: Gestalt therapy; emotion-focused therapy (EFT); schema-therapy; and cognitive-behavioral therapy (CBT). It is – in reality – an enactment of the relationship between parts of the self. The purpose of these enactments is to gain a new perspective on one's experiences and to attain a resolution of conflict between parts of the self, or between the self and an important other.

The authors [18] describe four major types of 'chairwork': **(a)** the *two-chair task* for enacting internal dialogues between conflicting parts of the self; **(b)** the *two-chair task* for enacting otherwise automatic process of self-interruption or self-censorship; **(c)** the *empty-chair task* for enacting dialogues regarding conflict with a significant other person; and **(d)** *compassioned-focused chairwork* for enacting affinity, compassion, or tenderness towards the self. There are then a couple of sub-sections on the 'History of Chairwork' and the 'Theoretical Development of Chairwork'.

Several sections follow: "Clinical Description and Indications", including sub-sections on 'Compassion-Focused Chairwork', 'Chairwork Across Different Therapeutic Approaches' and 'Contraindications'; "Assessment"; "Clinical Example"; "Landmark Studies and Previous Reviews"; and a "Research Review"; followed by the usual "Possible Negative Effects and Harm"; "Diversity Considerations"; "Limitations of the Research"; "Training Implications" and "Therapeutic Practices".

Dream Work and Nightmare Treatments

In Chapter 19, "Dream Work and Nightmare Treatments" (pp. 577-604), the authors [19] describe how working with dreams in psychotherapy goes back to the dawn of psychotherapy. *"Freud characterized the power of dream interpretation as the 'via regia' to knowledge of the unconscious."*

However, in the section on "Clinical Descriptions and Indications", under the sub-section on 'Cognitive-Experiential Dream Model' (CEDM), they state that:

> *"... only one method of dream work has as substantial body of research on its process and outcome. The Hill cognitive-experiential dream model is an eclectic approach that incorporates humanistic-experiential, psychoanalytic, Gestalt, cognitive and behavioral theories. Although in ongoing psychotherapy, therapists rarely follow the method exactly, Hill provided a structured approach that has been used to test the dream model empirically."*

The therapist explores the dream images with the client in depth, following the four DRAW steps:

18. Antonio Pascual-Leone & Tabarak Baher
19. Patricia T. Spangler & Wonjin Sim

> ***d****escribe the image in detail;* ***r****e-experience emotion related to the image;* ***a****ssociate the image to earlier experiences; and determine any* ***w****aking life triggers for the image. The therapist may ask the client to use all five senses (e.g., visual clues, smell, sound, touch) to describe each image.*

The next sub-section on 'Methods for Working with Nightmares' is somewhat surprising, though these nightmares might happen to provide material to work with in therapy. There are three methods described for working with nightmares: **(i)** imagery rehearsal therapy; **(ii)** exposure, relaxation and rescripting therapy; and **(iii)** nightmare decongestion and reprocessing.

> *All of the methods begin with* ***psychoeducation*** *to provide information to clients about nightmares and their relationship to trauma, anxiety, image or task in action and assists with working through obstacles including persistent negative images.*

These methods include: Imagery skills, Exposure to nightmare content, Relaxation skills, Identifying themes & making meaning, Reprocessing and Imagery rescripting. Sections on the three methods then follow and these are followed by a sub-section on: 'Indications and Contraindication'.

The usual sections on "Assessment", "Clinical Examples", "Landmark Studies and Previous Reviews", and then the "Research Review", which mentions 8 studies; followed by: "Possible Negative Effects and Harm", "Diversity Considerations", "Limitations of the Research", "Training Implications", and "Therapeutic Practices".

Meditation, Mindfulness, and Acceptance

This modern addition to the psychotherapy 'canon' of techniques that work is described in Chapter 20 on "Meditation, Mindfulness and Acceptance" (pp. 605-624), the authors[20] describe this *third wave* of cognitive and behavioral therapy that promotes behaviors associated with psychological health and well-being. However, it is also a 2,500-year-old Buddhist practice, most recently advocated by the Vietnamese Buddhist monk, Thich Nhat Hahn. Hundreds of randomized-controlled trials have been conducted investigating mindfulness meditation-based interventions alone and other acceptance-based techniques.

Meditation has been defined as a "family of complex emotional and attentional regularly training regimes developed for various ends, including the cultivation oof well-being and emotional balance". *Mindfulness* has been defined as a way of purposefully attending to present-moment experience without judgement. It is a special form meditation practice aimed at cultivating the capacity to orient attention non-judgementally toward the present moment. *Acceptance* methods enhance the patients' experience acceptance, defined as having or allowing private events (including painful ones) free of attempts at regulation – in other words, allowing things to be experienced without needing to change them, or push them away. (p. 606)

There then follow the usual sections on "Clinical Description and Indications", "Assessment", "Clinical Example", "Landmark Studies and Previous Reviews", a "Research Review", "Possible Negative Effects and

20. Simon B. Goldberg, Christopher Anders, Shannon L. Stuart-Maver & D. Martin Kivlighann III

Harm", "Diversity Considerations", "Limitations of the Research", "Training Implications" and "Therapeutic Practices".

Facilitating Behavioral Activation

In Chapter 21 (pp. 625-651) on "Facilitating Behavioral Activation", the authors[21] describe 'behavioral activation' (BA) as a psychological method aimed at increasing positive interactions between a person and their environment. It is aimed particularly at the millions of people suffering with depression.

> *A structured, brief psychotherapeutic approach that aims to (a) increase engagement in adaptive activities (which often are those associated with the experience of pleasure or mastery), (b) decrease engagement in activities that maintain depression or increase risk for depression, and (c) solve problems that limit access to reward or that maintain or increase aversive control.* (p. 625)

Currently, there are four types of BA can be distinguished: (1) Pleasant activity; (2) Self-control; (3) Contextual BA; and (4) Behavioral activation treatment for depression. It is relatively simple, compared to full CBT.

> *"The basic idea of BA is that therapists help patients find which activities are related to a better mood and then work to build more of these pleasant activities into the patients' lives. This method does not require higher level patterns of thoughts, which for many patients are quite complicated and require an intensive learning process. ...*
>
> *... Because BA is relatively easy for both therapists and patients, it has also been used with patients suffering from other disorders and more complicated populations. These groups include caregivers of dementia patients, children with physical disabilities, adults with post-traumatic stress disorder, bereavement, anxiety and depression in cancer survivors, concurrent methamphetamine dependence and sexual risk for HIV acquisition among men who have sex with me, and as a preventative intervention for college students"* (p. 626)

Whilst this technique could probably be seen more as 'psychoeducation', it is relatively easy to include this into a battery of techniques that work, but this should not – in any way – be seen as an alternative to 'proper' psychotherapy, but as one of the possible additions to a battery of techniques.

There are then the usual sections that include: "Clinical Description and Indications", "Assessment", "Clinical Example", "Landmark Studies and Previous Reviews", a "Research Review" of 22 studies, "Possible Negative Effects and Harms", "Diversity Considerations", "Limitations if the Research", "Training Implications" and "Therapeutic Practices".

Cognitive Restructuring

This technique is based on cognitive theory that posits that cognitions are a key determinant of human behavior and emotion, which stem from *schemas*, that are the assumptions and attitudes derived from previous experience. When these are maladaptive, the associated based cognitions lead to the aetiology and maintenance of psychopathology. So, if the clients can identify, evaluate and correct their inaccurate beliefs and their underlying

21. Pim Cuijpers, Eirini Karyotaki, Mathias Harrer & Yvonne Stikkelbroek

dysfunctional schemas. This "Cognitive Restructuring" (CR) is outlined in Chapter 22 (pp. 652-675). The authors [22] both define this method and outline how this technique can be used differently across the cognitive-behavior therapies.

> *The generic process of CR – teaching clients how to identify, evaluate, and correct their inaccurate beliefs and their underlying dysfunctional schemas – is employed in multiple forms of individual psychotherapy.*

The section on "Clinical Description and Indications" include a list of examples of CR: Report thoughts; Relate thoughts and mood; Distancing from beliefs; Examine available evidence; Search for alternative explanations; Think about implications of beliefs; Consider different perspectives; Recognize cognitive errors; Explore personal meaning; and Test beliefs prospectively. (p. 654)

There are following sections on: "Assessment"; "Clinical Examples"; "Landmark Studies and Previous Beliefs"; a "Research Review" that lists 5 studies in Table 22.2 and 7 studies in Table 22.3; "Possible Negative Effects and Harm"; "Diversity Considerations"; "Limitation of the Research"; "Training Implications"; and "Therapeutic Practices".

Skills and Methods That Work in Psychotherapy

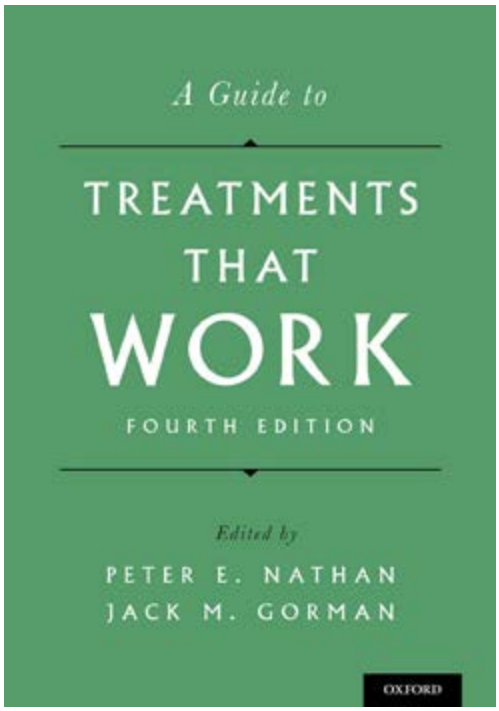
The last chapter, Chapter 23, (pp. 676-701) summarizes the work of the Task Force on Psychotherapy Skills and Methods That Work. The authors of this Chapter are the same as the Introduction and they describe some of the processes involved in compiling this volume. The summary of the techniques (Table 22.1) lists the number of studies, the number of clients / patients, the type of analysis, the results of the research review, and the consensus on the research evidence. The rest of the chapter summarizes the various sections and the "Task Force Conclusions".

In this extended book review, I have tried to describe and enumerate the various "methods that work" in psychotherapy, outlined in this volume and backed by substantive evidence, for the edification of our readers. If any one of these techniques interests you sufficiently to read up on this further, and to consider including it into your psychotherapy practice, then this review has done its task sufficiently.

Courtenay Young
Editor IJP

22. Iony D. Ezawa & Steven D. Hollon

BOOK REVIEW 2



A Guide to Treatments that Work (4th Ed.)

Peter E. Nathan &
Jack M. Gorman (Eds.)

New York: Oxford University Press, 2015
Hardback: pp. xxvii; 956
ISBN: 978-0-19-934221-1
RRP: £81.00; $118.82; €121,59

This massive tome presents (slightly outdated) and informed reviews of research on 'treatments' that work for a wide range of mental disorders. The 2007 3rd edition ran to 'only' 784 pages: this 4th edition nearly reaches a millenial number of pages. The original book project apparently came out of an APA Division 12 task force that made the significant decision to broaden its scope to include efficacious treatments, whether psychosocial or medical in type. The chapters in this book provide detailed specifications of the methods and procedures to ensure effective treatment of the various DSM disorders.

Each chapter in *A Guide to Treatments That Work* follows the same general outline: a review of diagnostic cues to the disorder, a discussion of changes in the nomenclatures from *DSM-IV* to *DSM-5*, and then a systematic review of research, most of which has been reported within the last few years, that represents the evidence base for the treatments reviewed.

Given the known biases within the structure and purpose of the DSM, this may put off a number of our Journal readers: here, I refer back particularly to the 2013 controversy around DSM-5, which was criticised widely

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for: (i) lacking a scientific basis, focusing more on symptomology instead of the biological underpinnings of mental illness; (ii) presenting a culturally biased perspective of normality; (iii) pathologizing shared human experiences; (iv) it perpetuated a pharmaceutical-first approach to treatment; (v) it lowered diagnostic thresholds so that virtually anyone can be diagnosed with a lifetime label; (vi) it created a "false-positives" problem of setting a valid boundary between disorders and normal variations; and, eventually, (vii) the National Institute of Mental Health (NIMH) withdrew its support.)

So, this book contains a chapter about the controversy around DSM-V, based (in part) on the failure to produce 'biomarkers' that would anchor mental disorder diagnoses to firm bases in neuroscience. The second main aspect to the controversy concerns the connections between psychiatry and "Big Pharma" and the medicalization of ordinary life. Unfortunately, to my mind, this is where the Guide starts down a particularly slippery slope, possibly without properly realizing it.

In all, 26 of the volume's 28 chapters review the evidence base for 17 major syndromes. In order to develop "good science" for treatment of these diagnoses, there is an increasing use of Randomized Controlled Trials, and – in order for these trials to work – the "treatment" has to be manualized (so that it can be done in the same way by different researchers). There is also an unrealistic ambition to transform psychiatric diagnoses by somehow basing them on the exacting findings of neuroscience.

At this point, we are already so far away from what actually happens in psychotherapy – between two people in a room – that there is, not just an irrelevance, but a significant dissonance between this type of psycho-pharmacological approach and anything that tries to be considered as a 'proper' psychotherapy.

The paradigm of the use of these different diagnoses and trying to discover treatments that work for each of these 'conditions', is something like dissecting an animal in order to discover how it lives: it is impossible to discover this as – as a result of the dissection – it is now dead.

However, the book proceeds in its fairly massive way (somewhat like a supertanker under full steam). The 28 chapters in this edition cover a range of pharmacological, psychosocial and combined treatments. One interesting chapter (Cpt 2: by Walker & Bigelow) addresses some of the necessary changes to practice, program-management and governance, given the cultural differences of American Indian and Alaskan Native communities. But there is no similar overall consideration to other cultures within the USA, or indeed outside of it, except where actual studies have compared different populations. In this respect, it therefore seems culturally and sociologically blind.

The book then marches through a number of 'paired' chapters looking at non-pharmacological (or psychosocial, or cognitive and social, or just 'treatments) and pharmacological treatments for the listing of about 28 various disorders: primarily attention and conduct disorders in children; schizophrenia; bipolar disorder; depression; panic disorders, phobias, socialized and general anxiety disorders; obsessive compulsive; posttraumatic stress disorders; eating and sleep disorders; sexual dysfunctions; substance (ab)use and addictive behaviors; and finally neuro-cognitive and personality disorders.

I cannot – and would not want to – question the authenticity of the research; the academic rigor and 'science' of the approach; and the depth of examination of all the various studies. The references are generally extensive, and the index is very complete. The academic and scientific qualifications of the 73 authors, all

listed alphabetically at the beginning, are also beyond reproach.

This book's main strength is that the authors are also – at least – considering an evidence-based approach to psychotherapy for many major psychiatric conditions, an area that many clinicians unfortunately neglect in their recommendations for treatment: preferring to "go to" the easier (and perhaps safer – for them) pharmacological route to treatment.

Essentially, this book feels like a companion volume to DSM-V: therein, we have some evidence in a 'patient' of a recognized 'disorder'; and here, in this volume, is how a cautious practitioner might consider 'treating' that disorder. There are however, a few good points, as well as a couple of gems (although it is a bit like finding diamonds on the beach: few and far between).

There is no doubt that the book contains detailed evaluative reviews of current research on empirically supported treatments, written, in most instances, by very reputable clinical psychologists and psychiatrists for similar. Similarly, the standards by which the authors were asked to evaluate the methodological rigor of the research on treatments have remained high and provide information on the quality of that type of research on treatment efficacy and effectiveness.

However, there is only one small section (3 paragraphs) on "practice-based knowledge" (pp. 26-7) – that provides any respite; one mention of client-centered therapy (p. 856); one mention of community-based eclectic treatment (p. 150); and within the various index listings on 'psychotherapy' – 1 mention of brief eclectic psychotherapy; 3 mentions of psychoanalytical psychotherapy; 3 mentions of inter-personal psychotherapy; 2 mentions of short-term dynamic psychotherapy; 1 of supportive expressive (psychoanalytic) psychotherapy: so that one gets a strong feel of the classic divide between research and actual practice and the continual 'focus' on the claim that CBT (Cognitive Behaviour Therapy) is – effectively – the only evidence-based therapy, which – of course – it is not!

There are a multitude of other studies that show that this is not the case; that nearly all psychotherapies are equally effective; and that the most effective components are: (a) the client-therapist relationship; and (b) the client's motivation or motivational enhancement therapy (mentioned very briefly in the chapters on addictions and substance abuse).

The second major 'strength' is the astonishing collection of reviewed research on pharmacological treatments and psychotropic medications for psychological and psychosomatic or psychosocial disorders. It is probably one of the more comprehensive discussions of psychiatric disorders and treatments. Unfortunately, being (just) a psychotherapist and not able to prescribe medications, this book has little relevance for me, except in 'suggesting' to referring GP colleagues that 'this' or 'that' medication might be more or less useful – so there is a tendency (on my part) to avoid or overlook the pharmacological treatment chapters in this book, though for others (like psychiatrists) this may be different.

Therefore, my examination focussed more on the non-pharmacological treatments: as for ADHD; Behavioral Parent Training, Classroom Management, Child Skills Training, Cognitive Training and Neurofeedback, and Multimodal Combination Treatments were examined; and for Conduct Disorder (CD), similarly, parent management training, multi-systemic therapy, multidimensional treatment foster care, cognitive behavioural therapy, functional and brief strategic family therapy and the 'Good Behaviour Game'.

In Chapter 7, 'Cognitive and Social Cognitive Interventions for Schizophrenia', are consid-

ered. In Chapter 10, 'Psychosocial Treatments for Bipolar Disorder', like psychosocial education and family-based interventions seem effective in higher rates of and faster times of recovery are looked at – however only as secondary adjuncts to pharmacology. Again, in 'Treatments for Paediatric Depression' (Cpt. 12), in severe to moderate cases, medication treatment is recommended with CBT and Interpersonal Psychotherapy seen as secondary: and so, it goes.

When the various chapter authors look at the efficacy of CBT for persons with panic disorder, and similarly for patients with moderate to severe agoraphobia, Social Skills Training is recommended for social anxiety disorder, along with relaxation techniques and exposure-based methods. However, separate chapters also look at combination (both pharmacological and psychological) treatments for major depressive disorders, obsessive-compulsive disorder, posttraumatic stress disorder, generalised anxiety disorder and social anxiety disorder, as being the most effective.

Having been diagnosed with a sleep disorder, I was very interested in the chapter 'Treatment of Sleep Disorders' (Cpt. 21). However, despite the fact of examining research on seven categories of DSM-5 sleep-wake disorders, I was somewhat disappointed to read that: *"Non-restorative sleep is no longer a feature of insomnia in DSM-5"*. Again, the non-pharmacological 'remedies' or 'treatments' are diverse: CBT-1; stimulus control; relaxation techniques; biofeedback; sleep restriction (!); sleep hygiene; and cognitive therapy; whereas the various pharmacological 'remedies' included: benzodiazepines; non-benzodiazepines; sedative antidepressants; Ramelteon; Mirtazapine; sedative anti-psychotics; Melatonin; Valerian root; and Antihistamines.

No mention – until almost the end of the chapter - of what was 'prescribed' (suggested) for me (and several thousands of others with breathing-related sleep disorders), like sleep apnoea: C-PAP (continuous positive airway pressure) masks, oral appliance therapy, surgery, oxygen therapy and lifestyle changes, more exercise, less alcohol, avoidance of caffeine, losing weight, quitting smoking, sleeping on the side (rather than on back or stomach), etc. However, a series of short paragraphs at the very end did cover – almost as an afterthought – circadian rhythm disorders; shift work disorders; jet-lag disorders and parasomnias (where there are undesirable physical effects, like nightmares, REM sleep disorders, restless legs syndrome, etc. The references were – as to be expected – legion.

I was also interested in the next chapter, "Pharmacotherapy and Psychotherapy for Sexual Dysfunctions" – not, I hasten to add, because of any personal affliction, but because several of my clients have reported such. Otherwise, the (non-pharmacological) *"treatment of sexual dysfunctions can be divided into five eras: the psychoanalytic, the early behavioural, the Masters and Johnson, the neo-Masters and Johnson, and the current psychobiological"*. It is a pity that the available research – other than into pharmacology - is announced to be relatively poor and, apparently, Sildenafil (Viagra) is still the drug of choice for erectile dysfunction., though Dapoxetine (and some other SSRIs) seem to help with premature ejaculation. The rest of the chapter dealt with different terminologies (Nosology: mainly between DSM-IV and DSM-V) and Epidemiology, before we came back to a recitation of various (mainly) pharmacological treatments for various dysfunctions.

I hope I am conveying the general level of frustration that I experienced when reviewing this book: perhaps I was the wrong person to appreciate that incredible amount of 'science' that it represents; I am – just – a clinician of about 40 years standing working with a wide

range of ordinary people. I had hoped – in making a presentation – to a university training course about "What Works in Psychotherapy and Counselling" to get more from this book than I did: I was – frankly – quite disappointed.

Another on-line reviewer states that, in their opinion, the biggest problem facing psychotherapy is that, by far the biggest determinant of the effectiveness of any psychological treatment is ***how*** the treatment is delivered, and not ***which*** treatment is delivered, and I am afraid that I have to concur – and most outcome research also points that way as well: that it is the therapist-client relationship that works, not the manualised treatment.

There is little mention of any other types of research, or any different measures of efficacy. Finally, with respect to the pharmacological 'treatments' – if you define 'treatment' as the removal or alleviation of symptoms, then these forms of treatments may well be efficacious: however, if psychotherapy is about healing the soul – as the word implies – (*psyche* and *therapia*) – then this book, despite its huge size and high academic status – has a long way to go.

COURTENAY YOUNG is a UKCP-registered Psychotherapist, who works in the NHS and also privately; he is a member of the BPS; on the Scientific & Research Committee of the European Association for Psychotherapy; and is the current Editor of the International Journal of Psychotherapy (www.ijp.org.uk). He has written and edited several books and many published articles, available on or through his website: www.courtenay-young.com

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- **Medium articles** (2000-3000 words); or
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References: The author **must** list references alphabetically at the end of the article, or on a separate sheet(s), using a basic Harvard-APA Style. The list of references should refer only to those references that appear in the text e.g. (Fairbairn, 1941) or (Grostein, 1981; Ryle & Cowmeadow, 1992): literature reviews and wider bibliographies are not accepted. Details of the common Harvard-APA style can be sent to you on request, or are available on various websites. In essence, the following format is used, with **exact** capitalisation, italics and punctuation. Here are three basic examples:

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GROSTEIN, J. (1981). *Splitting and projective identification*. New Jersey: Jason Aronson.

(3) For chapters within multi-authored books:
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